

DOCUMENT RESUME

ED 293 081

CG 020 729

AUTHOR Hurst, Hunter, Ed.; And Others
TITLE Drugs.
INSTITUTION National Center for Juvenile Justice, Pittsburgh, Pa.
REPORT NO ISBN-0-910099-06-5
PUB DATE Jul 84
NOTE 80p.; For related volumes, see CG 020 728 and CG 020 730-731.
AVAILABLE FROM National Center for Juvenile Justice, 701 Forbes Avenue, Pittsburgh, PA 15219 (\$10.00).
PUB TYPE Collected Works - Serials (022)
JOURNAL CIT Today's Delinquent; v3 Jul 1984

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS Adolescents; *Delinquency; *Drug Abuse; Drug Rehabilitation; *Substance Abuse; *Youth Problems

ABSTRACT

This document contains the third volume of "Today's Delinquent," an annual publication of the National Center for Juvenile Justice. This volume deals with the issue of drugs and includes articles by leading authorities in delinquency and substance abuse who share their views on causes and cures for the drug problem among youth in this country. Articles include: (1) "Social Factors and Substance Abuse" (Abraham Twerski); (2) "Delinquent Behavior, Drugs, and Alcohol: What is the Relationship?" (Ronald Akers); (3) "A Brief Commentary on Akers" (Travis Hirschi); and (4) "Witches and Wizards: The Treatment of Adolescent Drug Abuse" (Thomas Sumansky). (NB)

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TODAY'S DELINQUENT

VOLUME 3, 1984

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TODAY'S DELINQUENT, Volume 3, 1984.
National Center for Juvenile Justice.

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Editorial Office: TODAY'S DELINQUENT, National Center for Juvenile Justice, 701 Forbes Avenue, Pittsburgh, Pennsylvania, 15219.

TODAY'S DELINQUENT is published annually by the National Center for Juvenile Justice, the research division of the National Council of Juvenile and Family Court Judges, Inc., Reno, Nevada. This publication is made possible through the support of the Grand Lodge of Free and Accepted Masons of Pennsylvania. Points of view or opinions expressed in this document are those of the individual authors and do not necessarily represent the official position of the Center, the Council or the Masons.

Subscription is \$10.00. All subscription and change of address information must be sent in writing to TODAY'S DELINQUENT, National Center for Juvenile Justice, 701 Forbes Avenue, Pittsburgh, PA 15219. (412) 227-6950.

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ISSN 0733-6551

ISBN 0-910099-06-5

Design by Vincent Dzierżki, Town Studios, Inc., Pittsburgh, PA

TODAY'S DELINQUENT

National Center for Juvenile Justice
Pittsburgh, Pennsylvania

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THE WHITE HOUSE

During the past several years, I have visited drug abuse treatment and prevention programs across the country and I have become convinced that the drug and alcohol problem, especially among our youth, is one we can no longer afford to ignore. It has reached epidemic proportions and is threatening to destroy an entire generation of young people.

But I know there is hope. And it begins with people in their communities, who care enough to get involved and learn effective ways to combat the problem. As we all work together—parents, youth, civic groups, educators, professionals, business and religious leaders, judges, law enforcement agencies—I know we can make a significant difference.

Sincerely,

Clancy Reagan

Foreword

We are especially pleased to present Volume III of Today's Delinquent. The subject matter of this issue is drugs, a matter of vital concern to us all.

William A. Carpenter
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Preface

This issue of *Today's Delinquent* is a classic. We succeeded in getting several preeminent authorities in delinquency and substance abuse to candidly share their respective views on causes and cures for the drug problem among youth in this country. While reviewing the manuscripts, oftentimes I found myself in heated disagreement with an author, and othertimes passionately nodding in the affirmative, but never yawning.

When was the last time you heard a World Class Scholar declare that he was *morally certain* of anything? Or, heard a doctor say that pain-killing drugs only serve to add addiction to the problems of people suffering from chronic pain? I've spent the better part of twenty-five years reading the works of, and listening to, accomplished persons on the subject of drug use, and I've never heard such straight, unequivocal kind of talk.

Not surprisingly, the writers have some divergence of perspective on what causes drug use, but they present a rarely-found congruence of views on what to do about the matter. The extent to which they agreed that the nuclear family is where prevention and correction of drug use must happen was remarkable. And each in his own turn offered constructive, if at times provocative, strategies for increasing the ability of American families to rear children free of drug use.

It seems only yesterday that every avant garde and self-respecting professor, student, and healer of the human psyche or body in the United States was either openly advocating experimentation with drugs, or doubting that drugs caused any harm, or deftly avoiding being pinned down on the subject. Consequently, the number of promising lives lost to drug overdoses or condemned to an eternity of involuntary "bad trips" is a measure often used to characterize the past two decades. The writings in this issue portend a brighter future.

Hunter Hurst

Social Factors and Substance Abuse*

Abraham J. Twerski

This is a unique opportunity. I find myself addressing an assemblage of not only eminent jurists and leadership of the Masonic Lodge of Pennsylvania but what is of even greater importance, those who have the distinction and the awesome responsibility of sharing and attending to the problems of the most vital segment of our culture and society: our youth—the future of the country.

We are, of course, as the agenda states, concerned with the issue of substance abuse, a problem which threatens the very survival of the country. But this is an old topic, and even in this one area there are so many aspects of the problem which we might profitably discuss that I find it difficult to confine myself to the subject matter. For example, we might update our information on the most widely used drug—marijuana—and recognize that we have been sadly and dangerously deluded. Many people—physicians, psychiatrists, and other health professionals—operate with data on marijuana that is so obsolete that it ranks with the pre-Copernican belief that the earth is the center of the universe or that the world is flat and if you travel, sooner or later you are going to fall off the edge.

The initial studies on marijuana were done in the late sixties when its use became widespread. The marijuana available then was less than one-tenth as potent as that available now. Since the initial studies on marijuana, all scientific reports have made a 180 degree turnabout and are stating a totally different story. But people like to remember what was said fifteen or twenty years ago. **How many are aware that**

*Address presented at the Pennsylvania Juvenile Court Judges Research Seminar, May 31, 1984, Harrisburg, PA.

marijuana produces brain cell damage four times as rapidly as alcohol? Or that after smoking only one joint there will be traces of marijuana remaining in the body for as long as 45 days. Or that experienced pilots who flew perfect flights, pilots who flew thousands of hours of air time, and who flew perfect flights on flight simulators, were given one joint and then told to repeat the flight on the simulator. Every one of them made at least one fatal error.

A group of accomplished mathematicians were given very difficult, complex mathematical problems. Of the group of 40 or 50, only 11 could do them all. They then took these 11 and got their agreement to participate in an experiment. They gave them one "joint"—one marijuana cigarette—three times a week. Now that's not heavy use. One marijuana cigarette three times a week for three months. At the end of the three months they gave them the same problems and none of them could do them. They waited a few months and came to the same mathematicians with the same problems they had done several months earlier. None of them could do them. That experiment is now five years in duration, and none of those 11 mathematicians have been able to complete those problems they did before using marijuana three times a week for three months. This indicated that **even with moderate use, there is some permanent impairment of the higher levels of thinking in abstraction.**

Given the widespread use of marijuana by our youth, am I really an alarmist when I say that the survival of our country is in jeopardy? We may have already lost some of the most brilliant minds because of the use of marijuana.

Or perhaps we might discuss the dereliction of medical educators in failing to provide physicians with training in the fields of addiction, substance abuse, and prescription of mind-altering drugs. I learned very little about this in medical school and there seems to have been very little change. This training failure has resulted

in many well-intentioned physicians unwittingly becoming the leading drug pushers in the country. The young people who are our concern today are being reared in homes where the medicine cabinets are generally well stocked with addictive drugs legitimately obtained by a doctor's prescription; drugs whose potency usually exceeds the adulterated merchandise on the street.

Relatively few physicians are aware of some scientific facts. **FACT: Over 40% of all general hospital beds in the United States are occupied by people who are there because of drug or alcohol abuse.** **FACT:** The most widely prescribed tranquilizers—such as valium—have far less medical justification than is generally assumed. They should rarely be prescribed for longer than two or three weeks. Further, for many transient anxiety situations, some empathetic human contact would often be far more valuable than the chemical. **FACT:** There are very few indications for prescribing sleeping pills. Scientific studies have demonstrated beyond any question that the most effective sleeping medications added only 20 to a maximum of 40 minutes of sleep per night, and after several nights are probably totally useless. **FACT: Narcotic pain killers are worthless in the management of long-term, chronic pain. Further, they invariably result in addiction with the ultimate re-emergence of the pain; but this time the pain re-emerges in an addict.**

We might also address our concern, in the land that came into being on the principle that all men are created equal, of insuring that every infant born should have the maximum of opportunities unfettered by impediments to his potential. **The destructive effects of the maternal use of alcohol on the fetus have been well established scientifically. There is no more question about it.** And indeed, there is no amount of alcohol so small that we can say it is absolutely safe during pregnancy. So all we ask is that a reminder be affixed to all alcoholic beverages stating

simply, "If you are or may be pregnant, be aware that alcohol may harm your unborn child." Have you seen bottles of alcohol? I've seen them. No such label appears. Why? Because those who have been entrusted with legislating and enforcing the laws of the land are themselves "under the influence"...under the influence of powerful economic forces which direct their votes if not their consciences.

The list of all we might discuss is exhaustive and our time is so limited. Those of us involved with the treatment of chemical dependency are always looking for methods of prevention. All that we have talked about is preventative: accurate information, training competent professionals, measures to forestall prenatal injury. Now let us continue to some broader topics, topics of a more abstract character yet I believe, and I think you will agree, topics of no lesser importance.

I do not purport to know the cause or causes of chemical dependence. I suspect that there are, however, some contributing factors and that those concerned with the problem of substance abuse, in whatever role, should know what these are. At the very least, we need to know the scope and the nature of the forces at work.

In interviewing youngsters entering treatment for substance abuse, two themes occur with great frequency. For whatever it's worth, I always ask, "Why have you been into drugs and alcohol?" Invariably the answer is either "I wanted to get high," or "all my friends were doing it," or sometimes both. Let's begin with the latter: my friends were doing it. We're talking about the role of peer pressure. There's no question whatsoever that peer pressure is of great importance in determining the young person's behavior. **But the very obvious question is, since parents and family are so often almost invariably opposed to and condemning of the use of drugs—mind-altering drugs, why is family pressure not more often an effective counter-force to peer pressure?**

We've already given a partial answer to this question: if Mom is popping her valiums and Father is drinking to excess, the non-verbal communication undermines whatever verbal admonishment may exist. That's part of the answer but it's not all of it. You see, **peer pressure is effective because it is real. It counts.**

It is most important to young people, to kids, what their friends think about them. Peers function according to the law of the system and although these laws are nowhere written down, they are the authority of the system.

Family pressure, family opinion, and family standards are part of the grown-up world. And the grown-up world functions not according to unwritten laws but according to laws that have been written down and laws that are enforced as the law of the land. As I understand it, that law states clearly and unequivocally that a youngster need not take into consideration any of the moral values or standards of the parents. For the nation's nine pre-eminent jurists have ruled that a fourteen-year-old girl's sexual behavior is none of her parent's concern. Not only is parental consent not required for the dispensing of contraceptives, not only is parental objection of no consequence, but even simply informing the parent is not required. **And when the highest court in the land tells a young child that she may sleep with whomever she wants and thumb her nose at her family and need not be concerned with her parents' attitudes or values, why on earth should we expect that she or her boyfriend will care in the least what her parents think about the use of marijuana, cocaine, alcohol, speed, quaaludes, heroin, or whatever?** This tragic undermining of the family under the misguided perception of protecting the rights of young people is most unfortunate.

When young people tell us they use drugs in order to get high, I ask them what must be a stupid question: "Why do you want to get high?" And the stupidity of the question lies in that I already know the answer.

Invariably: "Why not? What else is there?" I would very much like to find fault with someone here. I would like to blame people but I can't find a scapegoat. **Who is responsible for the emergence of the philosophy that there is nothing more to life than getting high?** You have heard statistics about the number of young people dying *accidental* deaths due to alcohol and drugs, but the number of completed *intentional* suicides by adolescents averages 14 youngsters a day in this country. And another 5 times that many have an unsuccessful suicide attempt. What has happened to our young people to make so many of them see life as pointless, worthless, and hopeless?

Have the guardians of philosophy been teaching that there is no more to man's existence than the obtainment of pleasure? Or have the guardians been derelict in their duties or inept in their capacity to communicate? Or have they been undermined by an attitude which dictates that the only religion that can be taught in the schools is the religion of science? The only permissible doctrine seems to be that of science. Virtually all of this so called "proven" fact falls into the oblivion of obsolescence year after year after year. Nevertheless, science continues to exert its exclusive right to unassailable truth.

What must young people derive from the obsession and paranoid preoccupation with excluding prayer in the halls of schools while they daily see the sale of drugs going on in those very buildings and no one gives a damn? Now I know what the constitutional arguments are, but **may not some children draw the obvious conclusion? Namely, that marijuana, speed, and quaaludes must be far less harmful than prayer because no one seems to be concerned with keeping drugs from being dispensed in the school but everybody makes a great commotion about prayer.** Obviously, prayer must be more harmful than drugs.

Some very strange consequences have resulted from

our intense efforts to protect freedom and avoid all constraints on behavior whenever possible. And I know I'm treading on dangerous ground when I approach this issue for, after all, our nation was conceived and founded on freedom. Do we not worship, and rightly so, at the shrine of freedom and liberty? I'd like to share with you a story I heard about an elderly gentlemen. When he was a child, the only means of transportation his father had was his bicycle. This was in the days before a bicycle had coaster brakes and one could only stop those things by sheer brute force. He was too little to ride the bike and so it was off limits to him. One day he saw the bike standing there leaning against the house; no one was there to stop him, and temptation got the better of him. He mounted the bike and as he began coasting around the countryside he had the exhilarating feeling of "I'm free!" How wonderful it was to feel free. Then the bike began to go downhill and, try as he might, he couldn't stop the darn thing. His legs were far too short to reach the peddles. As the bike picked up momentum, carrying him along to only God knows where, he came to an important realization: "Hell, I'm not free, I'm loose!" Are we not capable of distinguishing between constructive freedom and suicidal looseness?

Central to the problem of chemical dependency is the issue of responsibility.

Controlling substance abuse by making chemicals unavailable is not likely to be successful. We tried that once with prohibition of alcohol and that didn't work, and our current effort at controlling illicit drugs by making them unavailable is hardly a smashing success.

Alcohol as a socially acceptable beverage is here to stay and since I'm not a temperance zealot, I find no fault with the judicious use of alcohol for those who can use it. The trouble occurs when there is irresponsible use of alcohol. This may be with the person who consumes more than he should; the alcoholic, for whom any amount is more than he should; or the person—alcoholic or nonalcoholic—who operates a motor vehicle under the effects of alcohol. At least as far as alcohol is concerned,

the issue is that of responsible versus irresponsible use.

I would think that it is not realistic to isolate and single out any one area of teenage behavior and address the issue of responsibility while condoning irresponsibility in other areas. If we demand the responsible use of alcohol in our young people, then we must insist on responsible behavior across the board.

This leads me to one of the problems for which our very being here attests, and that is the issue of responsibility in adolescents. Indeed, the very term "adolescence" requires it.

Sometimes the most insightful observations are made by persons whose thought processes have been liberated from the restraints of logic by mental aberration. I refer here to a young schizophrenic lad whose self perception was that he was a "nothing." And I asked him "Why are you a nothing?" He said, "Well, what am I? I'm not a child and I'm not an adult. I'm a nothing."

We conceptualize three stages of life: childhood, adolescence, and adulthood. Maybe this young schizophrenic knew a little better. Ancient cultures support the schizophrenic's position. There were puberty rites which constituted demarcation between childhood and adulthood. As long as a child was a minor, the parents bore full responsibility for his behavior. The very moment his childhood was terminated, in one second, he became an adult, both competent and responsible for his deeds and actions. There was no period of being in limbo. There was not a "no man's land," no time in which there was a tenuousness or suspension of responsibility or accountability. But Western civilization was progressive, innovative, and enlightened. **So we've "improved" upon the wisdom of the ages. We've created an entity known as "adolescence" wherein the youngster is too old for his parents to bear responsibility for him, but too young for him to bear responsibility for himself.**

Along with this creation of adolescence came the concept of the juvenile court system. Simultaneously, I think that, at least among the lay population, there has developed a concept, a philosophy, that a fifteen-year-old is somehow different from an adult. I believe that even the most ardent advocates of capital punishment would not ask for the death penalty for an adolescent convicted of murder nor perhaps even for life imprisonment. I'm not arguing against the merits of rehabilitation. I understand that youngsters are different from adults.

Rather what bothers me is a two-tier justice system which seems to be in vogue and the interpretation that this somehow diminishes the responsibility of an adolescent. For example, when I read the Old Testament, the degree of responsibility to which a thirteen-year-old is held is no less than that to which a forty- or fifty-year-old person is held. I do have a concern that the attitude whereby an adolescent is held to less stringent rules of life and a diminished sense of responsibility, may play a role in the epidemic of substance abuse among young people. **In fact, mind-altering drugs do impair judgement and interfere with responsible behavior, and that is central to the entire problem of chemical abuse.**

My concern goes even further. I think that responsible behavior can be seen as analogous to a hermetically sealed container. Once there is the smallest puncture, the smallest breach in the enclosure, and a tiny bit of air is permitted to enter, the entire protection is lost. And I think that a person who experiences in his lifetime even one moment in which there is no absolute responsibility for his behavior somewhere, then the hermetic seal is broken and perhaps a full sense of responsibility may never again be achieved. **The anti-social adult is not necessarily the adult who was a juvenile delinquent, but may be the physically grown-up adolescent who was permitted to have a socially sanctioned**

phase of diminished responsibility.

Although social change is hard to come by, we must begin somewhere. We may not succeed at revolutionizing cultural concepts, but that doesn't exempt us from trying. And who can be more effective leaders in this venture than those who are so often confronted with the disastrous consequences of substance abuse. Perhaps from this gathering, the National Center for Juvenile Justice, and from the conference of the Grand Masters, could come a call for improved education and training on substance abuse. **We should demand that all biological and behavior science schools teach their students and graduates, whether they be doctors, psychologists, social workers, or ministers, about alcohol and substance abuse** as they are not doing now, even in 1984. I find nothing wrong in having a resolution coming from NCJJ or from the Masonic order urging the deans of schools of medicine, social work, psychology, among others, to get their heads out of the sand and begin learning and teaching. If they don't respond, I see nothing wrong with contacting legislators and insisting that unless these schools live up to their responsibilities to train service providers in the nation's number one health problem that their funding should be curtailed. That usually makes them listen. **I believe that the loss of respect for parental authority directly contributes to substance abuse.** Those in attendance here, juvenile and family court judges, should help us—physicians, psychologists, psychiatrists, lay people—be in search of methods to re-establish both responsibility and authority within the family. **Parents should not be permitted to relinquish responsibility for their children and children should be expected to respect the authority of their parents.** I believe that the voices of those present and those whom you represent should be heard loudly in condemning the laxity in dealing with drunk driving. **No where is irresponsible behavior so**

manifestly condoned as in drunk driving.

I had a call recently from a patient whose license was revoked last week. He's now sober 10 months. The license was revoked at the court procedure which took place 10 months after the offense. That seems a little bit late. At whatever age, the consequences should be rapidly implemented and appropriate to the grave offense of drunk driving.

I know it is not up to the judiciary to invoke the cause of religion, yet there is no escaping the fact that many youthful offenders have behaved in a manner compatible only with hedonism: get what you can when you can and avoid any higher goals and purposes. Whether one ascribes to theologic positivism, humanism, or any other life philosophy, whether it is theistic or non-theistic, is totally immaterial; but **something other than the aspiration to get high must be given to our youth, whatever shape or form it may take.** We need to hear your voices clearly, so that those who can deliver the message should perhaps be stimulated to do more than they are doing.

Finally, as those who deal day in and day out with adolescents, please help our society understand that while there are of course differences between young people and grown-ups, these differences are in the areas of growth, education, training, and rehabilitation but should not be in the area of diminished responsibility. We must not give the youth of our country a reason to think and feel what the psychotic young man said—"I am neither a child or an adult so I am nothing." Let them recognize that this is wrong. Perhaps we can help society redefine and establish its values and ideas so that young people will feel, not that they are nothing, but that they are indeed SOMETHING, indeed very great things, and perhaps then behave accordingly. So that's your assignment. Let that be your jobs.

Delinquent Behavior, Drugs, and Alcohol:

What is the Relationship?*

Ronald L. Akers

Clarifying the Issues

Drug consumption in American society is widespread. It is now unusual for someone to pass through the teen years without knowledge of drugs, knowledge often obtained through direct personal experience. This contrasts sharply with the situation in American society not long ago. **Although there is evidence that the consumption of illegal drugs by teenagers has very recently declined, the prevalence of drug use remains ten times what it was two decades ago.** Clearly, the amount and frequency of substance use and abuse among juveniles remain a social problem of gigantic proportions—an exceedingly important and excruciatingly painful problem. Substance abuse continues to exact a tremendous toll directly on our youth, and it continues to affect adversely their relationships in the family, school, and community.

Consumption of drugs and alcohol by teenagers wreaks havoc on the highways. As dealers, customers, and consumers, teenagers play a significant part in the illegal drug market. This market, in turn, sustains criminal activities with a size and economic impact rivaling all but our largest legitimate industries. One does not have to be an alarmist to see that the use and abuse of drugs and alcohol among our young people

*Portions of this paper are based on or taken from *Deviant Behavior: A Social Learning Approach*, 3rd edition, forthcoming from Wadsworth Publishing, Belmont, CA, and from a paper presented to the American Society of Criminology, November, 1983. I wish to thank John Cochran for assistance in data analysis. I also acknowledge Marvin D. Krohn, Lonn Lanza-Kaduce, and Marcia Radosevich, who were my associates on the Boys Town Study.

is one of our most pressing social problems. We have responded with large, ongoing, and costly prevention, treatment, law enforcement, judicial, and institutional efforts, and—some consolation—it is possible that the recent moderation in teen drug use may be in part attributed to these efforts.

Much the same picture can be painted regarding the prevalence of other juvenile deviant behavior. The level of violence, theft, and destruction by juveniles surged forward for more than two decades. In spite of some recent indicators of abatement, the level of juvenile arrests and juvenile court caseloads are still at historic highs. As in the case of drugs, we have responded with a variety of official and unofficial control, treatment, and prevention programs, often with more effect than the "nothing works" philosophy would have us believe.

This similarity between the behavior of substance abuse and delinquency leads easily to the central question addressed in this paper: what is the connection between drug use and criminal behavior among juveniles in American society?

Drug use by adolescents *is* delinquent behavior by definition. Purchase and possession of alcohol by a minor are status offenses (and, therefore, no longer within the delinquency jurisdiction of the juvenile court in many places). Possession and sale of drugs are criminal law violations, except in those jurisdictions where possession of small amounts of marijuana for personal use has been reduced to less than a misdemeanor.

We can, however, frame the question in such a way that it does not have this self-evident flavor by noting that legal similarity does not necessarily imply behavioral similarity. The category of delinquency is not behaviorally homogeneous, but contains many different types of behavior, and we are thus able reasonably to ask about the interrelationships among the types. Measures of deviant drug use and measures of deviant sexual behavior, for example, may be in one sense simply different ways of gauging delinquency, and they may

both be part of a scale measuring overall delinquency involvement, but they are not the same behavior. By the same token, adolescents may burglarize homes and get into street fights. While these are both manifestations of delinquent patterns, they are different enough behaviorally that we can legitimately ask how they are related to each other.

But can we move from asking the central question in order to see how well our different measures of delinquency are intercorrelated, to thinking of one of them as the independent (cause) and the other as the dependent (effect) variable? May we say that fighting causes breaking and entering or, the other way around, that teenage burglary causes teenage fighting? We are faced with a similar issue with regard to the consumption and abuse of drugs as related to delinquent behavior. Drug utilization by adolescents is but one of several indicators of delinquent behavior but, for our purpose here, drug utilization will be treated as a separate variable from other types of delinquent acts.

We know that ingestion of some substances produces mood and behavioral change. Does it provide the immediate motivation to commit delinquent acts? Or does it lead indirectly to delinquency by inducing youngsters to engage in dealing in drugs, stealing drugs, or stealing money to pay for drugs? It is possible that drug use "causes" other delinquency in this sense. Although there is little about delinquent acts that could directly provoke drug use, it is possible that involvement in delinquency could lead indirectly to substance abuse through placing the adolescent in settings where drugs are available and acceptable. Also it is quite possible that drugs and delinquency are related because they both flow from another independent set of causes. **Whatever direction causality takes, we must begin with determining whether drug and delinquent behavior are correlated. If there is no association, the question of cause is moot. Correlation is not causation, but there is no causation without correlation.**

Multiple Drug Use

I shall begin by examining the correlations among the use of different kinds of drugs. In the 1960's, when smoking marijuana first began to spread among teenagers, a number of observers believed that drinking and drug use were not connected. Indeed, many thought that drinking was incompatible with drug taking, in that the more marijuana was used, the less the kids would be drinking. Some proposed that high school students could be divided into potheads and boozeheads. There were some doubts about this at the time and we have since learned that indeed marijuana and alcohol consumption are related. In fact, **while a great many young people drink without using marijuana, drinkers are more likely than non-drinkers to smoke marijuana, and almost all marijuana users drink.**

The assumptions about the links between marijuana and other drugs were opposite those about marijuana and alcohol. It was often assumed that, once marijuana use began, cocaine and heroin addiction would quickly follow. **But does smoking marijuana cause one to go on to use harder drugs? The answer is that, while smoking marijuana does not directly cause the youngster to progress to stronger hallucinogens or narcotics, use of one substance is related to use of another.** Use of all other substances is higher among marijuana smokers than among abstainers. Indeed, there is a high correlation among usage of all types of drugs. Using any one substance increases the probability that another substance will be used. Using legal substances is related to using illegal substances, and use of any illicit drug increases the chances of using other illicit drugs. Specialization in a particular drug is uncommon, although one drug may be used more frequently than other drugs by the adolescent. **The rule, then, is multi-drug usage.** This does not mean that drugs are typically mixed or consumed at

the same sitting. Instead, the adolescent takes up a new drug without giving up drugs previously used. The multi-drug syndrome develops progressively or hierarchically with the taking of harder drugs building on a base of alcohol and tobacco use, but with successively fewer users at each stage until only a few proceed all the way to frequent drug abuse with heroin or other opiates (Kandel, 1975; Kandel, Kessler, and Marguiles, 1978).

Does this interplay among different drugs extend to other forms of adolescent deviance? Is the initiation of drug use accompanied by the initiation of other delinquent acts? Does progression into multi-drug use or abuse patterns go along with progression into delinquency in general? I continue examination of this central issue by tracing historical trends in drugs and delinquency, by presenting some findings from my own research, and by reviewing the research literature on the connection between drugs and delinquency.

Trends in Substance Use by Adolescents

Illegal Drugs

Beginning in the 1960's and continuing into the 1970's, a heroin epidemic occurred among both adolescents and young adults, reminiscent of the rapid spread of heroin in the early 1950's. But, just as the earlier wave of heroin diffusion abated, so too did the more recent one, and the incidence of heroin use and addiction eventually declined. By the mid-1970's there were signs of a stabilization of heroin addiction. Evidence from the late 70's and early 1980's confirmed this. National surveys of high school seniors showed that the rates of heroin use had been cut in half and that daily use (indicative of addiction) virtually disappeared among this adolescent population between 1975 and 1982. Other national surveys evidenced declines in heroin use by both adolescents and young adults (Miller, Cisin, and Gardner-Keaton, 1983).

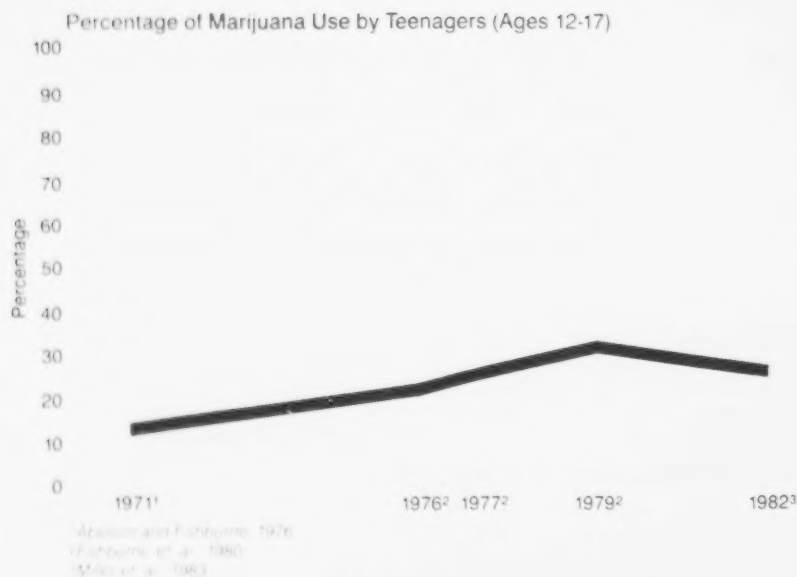
Marijuana was practically unknown in the United States before the 1930's. At first, it penetrated the slums of the big cities and became, along with heroin and

cocaine, part of the drug subculture. After World War Two, marijuana use spread rapidly among the youth of the lower-class areas of the cities, reaching a peak about 1949-1950 and continuing at a high rate until the mid-1950's. The practice began to decline somewhat toward the end of that decade. LSD and other hallucinogens were unknown to all except a small group of experimenters before the mid-1960's. To all intents and purposes, these drugs were absent from campus and from all other sectors of society, except for restricted drug subcultures. First marijuana, then LSD, amphetamines, and other drugs thereafter began to spread to college and other populations that had been virtually isolated from drugs.

The increase was most dramatic for young adults, especially college and university students. In 1965, less than 1 in 10 college students had used marijuana. By 1970, more than 4 in 10 had used this drug and more than 2 in 10 had used it within the past month. This trend continued throughout the 1970's so that, by the end of the decade, two-thirds of young adults had had some experience with marijuana and one-third were current users. Young adults in the military also took up drug use, reflecting the level and types of drugs used in the civilian population.

Significant increases also occurred among high school students. Figure 1 reveals that at the end of the 1960's about 1 in 10 of the population (12-17) had ever smoked marijuana. By the mid-1970's this figure had doubled, and by the end of the decade about one-third of America's teenagers had used marijuana.

The general trend in drug use throughout the decade was upward, particularly among older teenagers. In the wake of the spread of marijuana, there were increases in the use of LSD, amphetamines, barbiturates, and other drugs. There were, however, clear signs at the close of the decade and the beginning of the 1980's that this trend was slowing or even reversing for marijuana and several other illegal substances. While the percent of teenagers (12-17) who had ever used marijuana doubled



between 1971 and 1977 (from 14% to 28%), the rate of increase slowed but continued through 1979 and then declined such that by 1982, the portion of adolescents in the United States reporting some experience with marijuana was less than in 1977 (28%) (Fishburne, Abelson, and Cisin, 1980; Miller et al., 1983).

In surveys of high school seniors, the lifetime prevalence (percent who have ever used marijuana) tripled between 1969 and 1979 from 1 in 5 to 3 out of 5. It remained unchanged between 1979 and 1980, then declined in 1981 and 1982 to slightly less than 3 out of 5 seniors. (See Figure 2.) Moreover, the proportions reporting current use (within the past month) and daily use declined by 1982 to the lowest levels since 1975. To give some idea of the volume of use among high school seniors, daily use reached a peak of 11% in 1978. It has declined each year since (Johnston, 1973; Johnston, Bachman, and O'Malley, 1982).

Sedatives and tranquilizers were used by smaller and smaller proportions of the seniors throughout the last half of the decade. Several other drugs that had been taken up by ever-increasing numbers of young people in

the 1970's also stopped growing or showed significant decreases in use by 1980. These include PCP, inhalants, cocaine, LSD, and other hallucinogens. The proportion of young people reporting usage of illicit drugs besides marijuana (mainly stimulants, sedatives, and tranquilizers) has continued to increase but at a very slow rate (Johnston et. al., 1982).

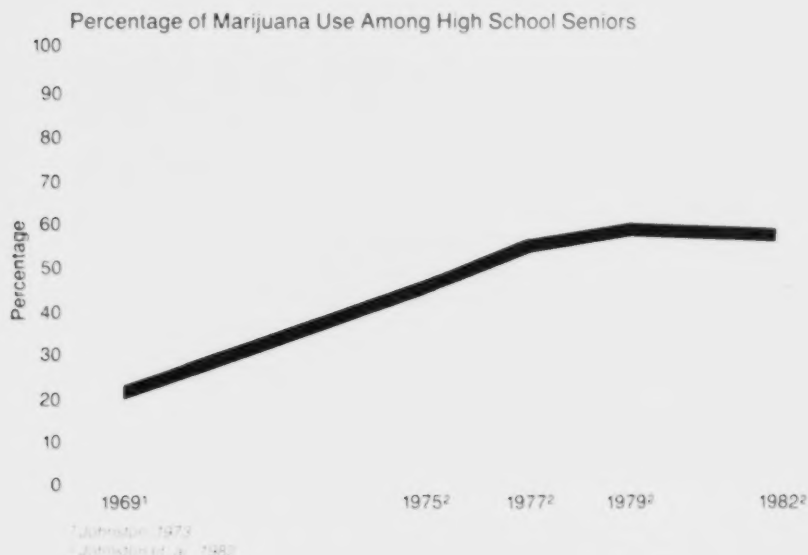


Figure 2

As noted above, while it does not directly lead to the use of hard drugs, smoking marijuana increases the risk of engaging in multiple-drug use. Therefore, as trends in marijuana go, so do the trends for many other substances. If the stabilization or decreases in marijuana smoking continue in the 1980's, the use of most other drugs will stabilize and decrease as well. This conclusion appears to be supported by the preliminary findings from the survey of 1983 high school seniors. The use of nearly all drugs remained steady or declined from 1982 to 1983. Daily use of marijuana among the 1983 seniors dipped to the lowest level since 1975, and the proportion of seniors ever having taken an illicit drug of any kind was down to 63% from 66% in the peak year of 1979 (NIDA news release, Feb. 7, 1984).

These behavioral trends have been accompanied by increasingly negative attitudes towards drugs among adolescents. In the National Institute of Drug Abuse (NIDA) surveys of seniors, the proportion believing that regular marijuana use is harmful declined from a clear majority in 1971 to 35% in 1978. The next year, however, there was a marked increase in this belief and, by 1980, a majority again felt that regular marijuana smoking presents a "great risk." In the 1982 survey, more than 3 out of 5 seniors held this belief. A similar pattern held for beliefs about LSD, cocaine, and other drugs (although not for amphetamines and barbiturates, where perceived harmfulness has slightly declined). Similarly, the percentage of seniors believing that marijuana use should be illegal declined through 1977 and then began increasing by the latest survey. In that survey, over one-third said it should be illegal in private, and well over two-thirds said it should be illegal in public (Johnston et al., 1982).

The legal substances (for adults), alcohol and tobacco, are still more often consumed than any of the illegal substances, and marijuana is clearly the most frequently taken illegal drug. Fairly small percentages of adolescents have ever used any of the other illicit substances. In 1982, about one in twenty of the teenagers in the national NIDA survey had ever tried LSD or cocaine, and less than one in two hundred had ever tried heroin. Some of the drugs have been experimented with by sizable percentages of the population by the time of young adulthood, but no illegal substance besides marijuana is used currently or regularly by more than 3% of persons aged 12-17 (Miller et al., 1983).

Teenage Drinking

Findings from various surveys over the years on the prevalence of drinking among adolescents are located in Figure 3. Today, over two-thirds of teenagers have drunk some alcoholic beverage, and nine of ten have tried some

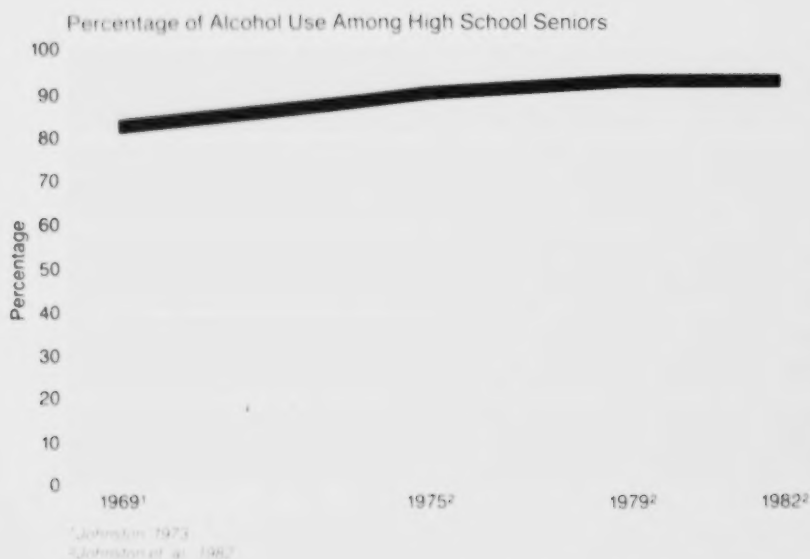


Figure 3

alcohol by the time of high school graduation. These figures are higher than in the 1950's and 1960's, but they have remained fairly stable since the mid-1970's with again some indication of a recent slight decrease. From one-third to one-half of the boys and one-third of the girls drink to an extent that would be labelled as at least moderate drinking if done by an adult. Few teenagers are high-frequency or large-quantity drinkers. However, about 3% can be characterized as problem drinkers, and only a few of these are alcoholic in the sense of the term when applied to adults. Nevertheless, while the proportions of teenage drinkers and problem drinkers has not changed much, there has been an increase since 1970 in the average quantity consumed by those who do drink.

Teenage Smoking

Trends in cigarette smoking among teenagers need to be discussed. At first, this may seem out of place in the context of drugs and delinquency. However, as Hirschi (1969) found, smoking cigarettes is related to delinquent behavior. Moreover, it has come to be defined as more

deviant in recent years (Akers, Massey, Clarke, and Lauer, 1983).

Teenage smoking increased steadily from the 1950's until the beginning of the 1970's. By that time, the majority of those in the 12-17 year-old group had experimented with cigarettes. About half as many girls as boys were regular smokers. At that point, the prevalence of smoking among boys stabilized, but continued upward among girls so that, by the end of the decade, their rate of smoking equalled, and now, by the time of high school graduation, slightly exceeds that of the boys (67% of senior boys and 72% of senior girls).

During the last part of the 1970's, daily smoking declined among both boys and girls from less than 1 in 4 in 1976 to 1 in 8 in 1979. However, in recent surveys, tobacco smoking has begun to increase slightly. Today, about one high school senior in five smokes on a daily basis. But only 3 in 100 smoke a pack a day, and only one in a hundred is a heavy smoker (Fishburne et al., 1980; Johnston et al., 1982; Miller et al., 1983). Consumption of chewing tobacco and snuff has increased noticeably among teenage boys. The national surveys have not asked about this kind of tobacco use but, in our surveys in one community in Iowa, we found that in 1980 more than one in ten of the boys used smokeless tobacco more than once or twice and, by 1983, this had increased to about 1 in 6. Smokeless tobacco is still virtually nonexistent among girls (Lauer, Akers, Massey, and Clarke, 1982).

Trends in Delinquent Behavior

Cohort studies are very popular in delinquency research (see the review in Gable and McFall, 1983). These studies follow a group of adolescents over time. Many things are known from these studies, including the fact that while only a relatively small number of adolescents commit the bulk of the serious offenses, a sizable minority acquire some kind of record of official contact with the police or court. However, it seems fair to say that neither the studies of police contacts in birth

cohorts, nor studies of self-reported delinquency, have allowed us to map trends in delinquency nearly as well as we are able to map trends in teenage drug use.

Arrest Data

Police data, of course, reflect police decisions and behavior as well as the behavior of the persons arrested; but, to the extent that arrests of juveniles reflect changes in juvenile delinquency, we can trace some of the trends through the Uniform Crime Report arrest statistics. According to these figures, the trends in juvenile arrests for all offenses follow a trajectory similar to that of drug and alcohol behavior just reviewed.

After a general tendency to increase in the 1970's, juvenile arrests for serious offenses began to stabilize and show some declines from the late 1970's into the early 1980's. Total arrests of juveniles for index crimes decreased 7% from 1981 to 1982 (Uniform Crime Report, 1983). Over the last five years of UCR figures, juvenile arrests for all crimes are down 15%. Arrests of juveniles for drug violations have shown especially dramatic decreases in recent years (down 43%). Arrests for liquor law violations have increased (up 18%), but the number of juveniles arrested for public drunkenness has declined. This overall decline in number of juvenile arrests is largely due to the fact that there are fewer persons under 18 in the population. (The population of persons 10-17 years of age declined by almost 10% between 1976 and 1981.) However, the age-specific rate of arrest has also declined slightly. Some part of this decline may well be due to actual decreases in commission of arrestable offenses by juveniles.

Juvenile Court Data

Not surprisingly, the number of juvenile court cases also declined during the same period. The percentage decline, however, was less than the decline in the juvenile population. Therefore, as shown in Figure 4, the rate of juvenile court cases continued to increase throughout

the 1970's, although it did dip slightly between 1980 and 1981.

It appears then, that the trends in both official arrest and juvenile court statistics have moved in the same direction as adolescent substance use and abuse statistics reported in the national surveys. Both increased in the late 1960's, continued upward through most of the 1970's, and have been on a downward path since the end of the decade.



The Correlation of Drugs and Delinquency: Findings from The Boys Town Study

The research my associates and I conducted among adolescents in three midwestern states was supported by the Boys Town Center for the Study of Youth Development and is therefore often referred to as the "Boys Town Study" (Akers, Krohn, Lanza-Kaduce, and Radosevich, 1979). It was conducted among public and parochial secondary school students in eight communities, however, and not on the population of residents at Boys Town.

Briefly, the research was a self-report questionnaire survey of about 3,000 students in grades 7 through 12 in seven communities in the midwest. Classrooms were sampled from the junior and senior high schools in the communities and questionnaires were administered to each student who had parental permission to participate in the study. Response reliability and validity coefficients were high and are generally fairly well-established in these types of surveys of self-reported adolescent deviance (Akers, Massey, Clarke, and Lauer, 1983).

The questionnaire contained items asking frequency of use of seven types of substances: tobacco, alcohol, marijuana, stimulants, depressants, psychedelics, and narcotics. Responses were scored on a six-point scale ranging from never to daily use. The respondents were presented with a separate checklist of other delinquent acts ranging from truancy to assault with a weapon. The responses here were on a four-point scale ranging from never to very often. Students were also asked how often they had been expelled or suspended from school, picked up by the police, and appeared in juvenile court.

The correlation between each of the substance use items and each of the delinquency items have been completed. A look at Table 1 leaves no doubt that substance use is intimately related to delinquent behavior in this sample of adolescents. All of the correlations are statistically significant above the .001 level. That is, they would not occur by chance more than once in a thousand times were there no relation in the population from which the sample was drawn. All are in the expected direction; that is, **the adolescents who report use of any one of the various substances are more likely than nonusers to be involved in each of the delinquent acts.**

Drug users are also more frequently kicked out of school, arrested by the police, and referred to juvenile court. The magnitude of the correlation is impressive, ranging from .30 (for tobacco smoking by simple assault)

to .83 (for use of narcotics by serious theft). A great many of the coefficients are .6 or higher.

Association (Gamma)¹ of Different Types of Delinquent Behavior and Sanctions With Use of Different Kinds of Substances

Table 1

Delinquent Behavior	Substances						
	Tob.	Alc.	Mar.	Stim.	Dep.	Psych.	Narc.
Truancy	.57	.68	.68	.73	.69	.74	.70
Runaway	.46	.33	.37	.54	.56	.60	.58
Sexual behavior	.52	.56	.64	.64	.62	.72	.70
Vandalism	.38	.51	.46	.39	.49	.40	.49
Auto theft	.46	.71	.66	.67	.71	.70	.69
Assault/light	.30	.42	.43	.37	.47	.40	.51
Assault/weapon	.42	.43	.48	.51	.56	.54	.50
\$2-50 Theft	.59	.57	.66	.66	.63	.72	.64
\$50 + Theft	.52	.77	.79	.69	.72	.78	.83
Sanctions							
School expulsion	.61	.56	.69	.64	.61	.68	.66
Police arrest	.52	.66	.63	.67	.65	.74	.75
Juvenile court	.58	.62	.60	.59	.64	.71	.60

¹The coefficients shown in Tables 1 and 2 are Gammas. Gamma is a measure of association for grouped variables. Gamma values may range from -1.0 to +1.0. Values of .3 or higher are considered to indicate a moderate relationship between 2 variables, values of .5 or higher are taken to indicate a strong relationship, and values of .7 or higher indicate an unusually strong relationship.

While there is not much variation in the strength of the relationship by type of drug or by type of delinquent behavior, it appears, on the whole, that smoking tobacco is less strongly related to the delinquency items than are usage of the other substances. The two items of personal violence, simple assault and serious assault tend to be less related to substance use than either the status or property offenses.

Data were also analyzed by constructing summary scales to measure degree of involvement in the status or minor offenses (truancy, runaway, and sexual delinquency), serious delinquency (vandalism, auto theft, simple assault, assault with a weapon, petty theft, and serious theft), and overall delinquency (involvement in both minor and serious offenses). The analysis in Table 2

shows even more unequivocally the strong connection between drug involvement and delinquent behavior. The correlations are all high. There is a tendency for the relationship to become even stronger as we move from tobacco, alcohol, and marijuana to the stronger and more socially disapproved substances.

Association (Gamma) of Minor, Serious, and Overall Delinquent Behavior With Substance Use

Table 2

Substances	Overall Delinquency	Minor Delinquency	Serious Delinquency
Tobacco	.66	.58	.48
Alcohol	.75	.63	.54
Marijuana	.76	.69	.58
Stimulants	.78	.73	.56
Depressants	.78	.78	.61
Psychedelics	.85	.78	.63
Narcotics	.82	.75	.64

This same pattern holds for both minor and serious delinquency. However, for all the substances the relationship is somewhat stronger with minor than with serious delinquency. But these differences are not great, and involvement with the milder substances carries nearly the same risk of involvement in delinquency as the stronger drugs. Also, the somewhat reduced correlations with serious offenses may be partly due to the fact that there is very little variation in how often the youngsters in this sample commit serious assault or theft. Thus, the youngster need not be taking the harshest drugs; those who use even the drugs considered innocuous are much more likely to commit other delinquent acts than those who abstain.

The nature of the relationships between drugs and delinquency are shown more graphically in Table 3 which compares the differences in degree of delinquent involvement between users and nonusers. For each substance the vast majority of abstainers have no delinquent involvement, and those who do tend to have committed status offenses. The majority of users on the other hand,

except for drinkers, have some delinquent experience, and a sizeable minority have committed serious delinquencies. **The proportions of drinkers and marijuana users with delinquencies is about twice the proportion among the abstainers. The differences are even greater for narcotic drug use. More than eight in ten of the adolescents who have used narcotics admit to some delinquent behavior, and a third admit to serious delinquent behavior.**

Percentages of Delinquent Behavior Among Users and Non-users of Substances

Table 3

	Delinquent Behavior			
	None	Minor only	Serious	N =
Substances				
Alcohol				
Non-users	91%	8%	1%	1218
Users	57	34	9	1541
Marijuana				
Non-users	84	14	2	1983
Users	39	46	15	778
Stimulants				
Non-users	80	17	3	2330
Users	28	53	18	424
Narcotics				
Non-users	74	22	4	2644
Users	17	50	33	118

Note: The distributions for smoking (similar to alcohol), for depressants (similar to stimulants), and psychedelics (similar to narcotics) are not shown.

Among users, the greater the level of drug use the greater the level of delinquency. This is true for every substance but, I will focus on marijuana here. As one moves from those who smoke marijuana infrequently (less than once a month), to those who smoke it frequently, the percentage of those with delinquencies increases

dramatically. Only 1 in 5 of the daily marijuana smokers reports no delinquency; 1 in 4 reports serious delinquent behavior, which makes the daily marijuana user five times more likely than the low frequency user to have committed serious delinquent acts. (See Table 4.)

Percentage Distribution of Delinquent Behavior by Frequency of Marijuana Use

Table 4

Frequency of Marijuana Use	Delinquent Behavior			N =
	None	Minor only	Serious	
Less than Once a Month	63%	32%	5%	539
Once or Twice a Month	48	42	10	205
Once or Twice a Week	39	44	17	221
Daily	22	54	24	199

Gamma = .68

The somewhat higher correlations between delinquency and the stronger psychedelic and narcotic drugs may be due in part to the tendency for those who use these drugs to use other drugs as well. As noted above, the research literature demonstrates a multi-drug use pattern particularly among those who take hard drugs because they progress to that point.

Table 5 presents findings which show that there is, indeed, a strong relationship between multiple drug use and delinquency. The large number of juveniles in this

Multiple-Drug Use and Delinquent Behavior

Table 5

Number of Different Substances Used	Delinquent Behavior			N =
	None	Minor only	Serious	
None	94%	5%	1%	1024
One	79	19	2	651
Two or Three	58	34	8	681
Four or More	24	54	22	377

Gamma = .73

sample who use no substance (do not smoke, drink, or use anything) are virtually delinquency-free. The odds change considerably with even one substance, and as multi-drug use develops so does more serious delinquency. At the extreme, 22% of the youngsters who have had experience with four or more drugs have also committed both minor and serious offenses, whereas only 1% of the abstainers have reached this level of delinquent involvement.

Correlation of Drugs and Delinquency: Review of the Literature

The findings in the Boys Town study strongly support the conclusion that drugs and delinquency are interrelated. These results are in agreement with other research. Almost all the research finds a substantial relationship between the use of drugs and other criminal and delinquent behavior. The more frequent and abusive the drug behavior, the more strongly it is connected with criminal and delinquent patterns. It is not, however, a linear relationship, and research has still been unable to establish its causal direction. Consumption of heroin, alcohol, marijuana, or other substances is not a direct cause of violence or crime. Only a small portion of those who drink, even of those who drink heavily, become seriously involved in crime. Nevertheless, in a large portion of criminal offenses, the perpetrators have been drinking or are under the influence of alcohol, and a large portion of apprehended offenders are heavy drinkers. The proportion of people using other drugs who also commit delinquent or criminal acts varies by type of drug and type of crime, but in every case, the proportion of users committing criminal acts is higher than for those who do not use drugs.

Early research established the connection between narcotic addiction and crime in adult populations (and one can assume that addicted juveniles would behave similarly). For instance, O'Donnell (1966) studied the criminal histories of federal narcotics cases and found

that while addicts did not uniformly commit crimes to pay for heroin, their criminal activities did dramatically increase following addiction. Similarly, Stephens and Ellis (1975) found that in four cohorts of addicts under treatment, about one-third had been involved in serious enough criminal activity to have been arrested prior to becoming addicted. However, there was a three-fold increase in the number of arrests following drug abuse—mostly property crimes. Weissman and his colleagues (1976) found a more than two-fold increase in crime among a sample of jail inmates from the pre-addiction stage of drug use to the period following onset of addiction. McGlothlin and his colleagues (1978) report similar findings.

To summarize, most of the research on drugs and crime over the past two decades has been done on adults and usually focuses on heroin addiction or alcohol abuse. These studies tend to draw samples and collect data from populations of arrestees, from prison or treatment populations, where they consistently found a strong relationship between substance abuse and crime. The relationships are clearest for alcohol and hard narcotics and are strongest with income-producing crimes, but drug use is related to the commission of violent offenses as well. Arrest frequently precedes the onset of abuse or addiction, but nearly all of the studies found an increase in arrest for non-drug offenses after drug use begins. There is the suggestion that income crimes are associated with heroin addiction because addicts need to resort to crime to pay for their habits. It is also proposed that alcohol (and sometimes other substances) have a direct pharmacological effect which either reduces inhibitions toward or induces violent behavior. However, there is little hard data to support this causal process, and the research is characterized by disagreement over what causes what and lack of data to answer the question adequately. **A specifically drug-produced motivation to commit crime that was not present prior to using drugs has not been established.** (See the

research reviews and studies in Gandossy et al., 1980; Inciardi, 1981; Collins, 1981.)

The research on drugs and delinquency in adolescent populations has also examined the addiction-crime connection, but is more likely to have looked at use of milder drugs and to utilize self-report studies of drug use and delinquent activity. The findings and conclusions are, nonetheless, similar to the research on adult populations. One of the earliest studies of drugs and juvenile delinquency utilized police, juvenile court, and other records from 1947-1953 (Kobrin and Finestone, 1968). Of those with official records as drug users, 90% were heroin users and resided in geographic areas with the highest rate of juvenile court cases. Delinquency involvement both preceded and followed heroin use.

In a survey of high school students, Hirschi (1969) found both cigarette smoking and drinking to be related to delinquent behavior. In a NIDA-funded study, Inciardi (1980) studied drugs and deviant behavior in both a campus sample and a street sample of young people. In the college sample, self-reported law violations were highest among those who were regular users (mainly marijuana and alcohol), especially those who were also involved in drug selling. Almost all in the drug abusers sample had official criminal records. Most of the offenses committed by the heroin addicts were drug sales, prostitution, and gambling, but over one-quarter were property crimes and there were a very few violent offenses. In a national NIDA survey of young men, a clear association was established between drug use and crime. The more one used drugs and the more one was involved in selling drugs, the more likely one was to have committed non-drug offenses (O'Donnell, Voss, Clayton, Slatin, and Room, 1976).

The best data on the sequence of drug and delinquent behavior over time in an adolescent population come from two national longitudinal surveys. The first is by Lloyd Johnston and his associates at the University of Michigan and the second is by Delbert Elliott and his associates at the University of Colorado. The Johnston

study, supported by NIDA, is an annual survey of high school seniors that began in 1970. Some of the findings from those surveys are highlighted in Figures 1-3. The Elliott research, supported by NIMH is a study in which a cohort was first interviewed in 1976 and interviewed each year thereafter for five years. **Since both of these studies are longitudinal they are able to trace the sequence of drugs and delinquent behavior over time. It is with these kinds of data that the question of causal ordering can best be addressed. Unfortunately, even they have not produced a definitive answer.**

Johnston found in the first year of the survey a strong relationship between marijuana, alcohol, cigarettes, heroin, and amphetamine use and delinquent behavior. For instance, of the high delinquency group 42% smoked marijuana and 88% drank alcohol, while in the low delinquency group only 6% smoked marijuana and 39% were drinkers (Johnston, 1973). Later, Johnston analyzed data for males over a period of years. The cross-sectional relationships for each year of the study were clear—the higher the level of drug use, the higher the level of delinquency. The relationship was stronger for a scale of theft/vandalism than for a scale of aggression, for minor rather than for serious offenses. However, the differences in delinquent conduct existed *before* drug use began. Nevertheless, *after* the drug-using group started on drugs, the difference between their delinquent behavior and that of the group who remained abstinent increased. The correlation between drug use at time 1 to delinquent behavior at time 2 was fairly weak and essentially the same as the correlation of delinquency at time 1 and drugs at time 2 (Johnston et al., 1978).

In the research by Elliott and his associates, the youngsters who used alcohol and marijuana and other drugs were found to be twice as likely to be involved in other delinquent activities and four times as likely to be committing serious offenses as those who abstain (Huizinga and Elliott, 1981). This strong tie between

drug and delinquency involvement continued in each year of the study for all types of drugs and for minor and serious delinquent offenses. For most categories of drug users, initiation of drug use in any given year was accompanied by increased delinquent involvement that year. The research did not permit examining the sequence of events within the same year but was able to trace the ordering of drugs and delinquency from one year to the next. The most common pattern was for the adolescent to continue with neither drugs nor delinquency, about 1 in 2, but the next most common sequence was for drug use to begin in a given year with no subsequent delinquent involvement in 1 out of 4. All other patterns were followed by relatively small portions of the sample, but the next most common ordering was for delinquent behavior to begin one year followed by the onset of drug use the following year. However, there was very little difference in the portion following this pattern and the portion who began drug use first or began drugs and delinquency in the same year (Huizinga and Elliott, 1981). Thus, the researchers found no strong support for the view that drugs cause delinquency or vice-versa.

Compared to the abstaining teenager, the drinking, smoking, and drug-taking teen is much more likely to be getting into fights, stealing, hurting other people, and committing other delinquencies. But the variations in the order in which they take up these things leaves little basis for proposing causation of one by the other.

Social Correlates of Drug and Delinquent Behavior

The reasonably clear conclusion then is that drugs and delinquency are highly related but cannot be said to cause one another. Depending on the substance, setting, and group, first commission of illegal acts will sometimes precede and some-

times follow first drug use. It appears, then, that delinquency and drug use are related through the association they hold in common with another set of social factors and processes. This hypothesis is

supported by the fact that, on the whole, drug use and abuse have the same social correlates as delinquency—age, sex, race, class, and residence as well as religion, family, and peer groups. There is a vast literature on the correlates of delinquency and nearly as much on the correlates of drug behavior. This is not the place to do a review of this literature, and I shall only attempt a brief outline of the major relationships found.

The preponderance of males in delinquent activity is also found in drug behavior although the male-female difference is not as great in the latter case, except for the use or abuse of harder drugs. For smoking, alcohol, and marijuana, the lifetime prevalence rates for adolescent boys and girls are about the same, and some substances are used by a higher percentage of girls than boys. Nonetheless, just as they tend to become more deeply involved in delinquency, boys tend to drink and misuse drugs more frequently than girls.

Theft, assault, vandalism, and other forms of juvenile crime tend to peak in the late teen years, whereas most substance use peaks a little later, in the early twenties. But for both, there is an overall negative correlation with age.

Social class and race are not related or are related in an ambiguous way to delinquency, except that the most seriously involved delinquents tend disproportionately to come from the lower class and minority racial groups. Similarly, drug use as a whole is not significantly related to class and race, but some forms of drug abuse and narcotic addiction are more heavily concentrated in the urban areas of highest minority population, poverty, and unemployment.

The southern region is the area with the lowest levels of drug use and abuse, and also the region with the

lowest rates of delinquency. Both drugs and delinquency are less likely to be found in rural than in urban or suburban communities.

Both drug and delinquent behavior are negatively related to strong, intact families with good parental supervision and relationships with children, to strong religious ties and commitments, and to good school performance and experiences. Parental behavior, models, attitudes, and discipline are related to drug and delinquent behavior.

By far the strongest correlate of both drugs and delinquency is the behavior of peer groups, especially friendship groups. **Indeed, the single best predictor of adolescent behavior, conforming or deviant, is the behavior of close friends.** Both drugs and delinquency are primarily group behavior. Peer groups provide the setting for first involvement and for progression into more serious involvement. The most significant models, favorable attitudes, and social reinforcement for conforming or deviant adolescent behavior are provided by peer groups.

Conclusions and Implications

The historical trends, prior research, and the new data reported here all agree that drugs and delinquency are closely tied. A clear implication of these findings is that, in spite of signs of recent abatement, judges, police, and juvenile workers need to continue to be alert to the drug dimension in delinquency. **The findings are clear that while abuse of any drug and use of the harder drugs are more strongly related to delinquency, even occasional use of substances is a pretty good sign of probable involvement in delinquency. Conversely, even minor delinquency may indicate involvement with drugs.** Thus, the fact that a juvenile may be in court, for instance, on a delinquency petition that makes no reference to drug offenses or drug abuse, does not mean that there is no

drug problem. **Delinquency referrals for drug violations are a fairly small proportion of all juvenile court cases, but this very much underrepresents the presence and importance of drugs in the overall delinquency problem.** We need to resist the tendency to view drug and delinquent behavior in isolation from one another or to see problem juveniles as drug cases or as behavior problems. Any program to which the court orders the juvenile for delinquency needs to have staff capabilities or referral sources for drug and drinking problems. Similarly, drug programs in the community should be capable of dealing with other forms of juvenile misconduct. The correlation of drugs and delinquency suggests that the greater the extent to which parents, schools, law enforcement, courts, and community programs can have an impact on one, the greater their impact on the other. To the extent that law enforcement programs designed to control the supply of drugs are successful, they should also have a downward effect on other forms of delinquency. Laws raising the minimum drinking age will not only reduce specifically alcohol-related offenses such as DWI (driving while intoxicated) and public drunkenness among teenagers, they should also reduce the level of general juvenile delinquency.

Research has yet to provide a definitive answer to the question of whether drug use causes the adolescent to get involved in delinquent behavior or is itself an additional deviant activity which follows from first engaging in law breaking. Even the studies with longitudinal data have been unable to determine clearly what causes what. For some juveniles, delinquency precedes illicit drug involvement; for others, substance use precedes delinquent behavior; and for others, they occur at about the same time. This lends support to the idea that both are caused by a third set of variables operating in the social milieu of the adolescent. Drugs and delinquency have essentially the same social correlates. These correlates are known to informed juvenile

court judges, social workers, juvenile probation officers, and others who deal with juvenile problems. Most realize, however, that the ability of the law and community programs to affect these variables is limited. Nonetheless, the court's disposition, for instance, is likely to take into account the family and community context from which the juvenile should be removed. The message from the research reviewed here is that this is precisely what needs to be done. Diversion and foster family, group home, and institutional placement options must be viewed with regard to the control of the juvenile and with regard to their possible effect on the family.

The importance of peers is also well known to those who deal regularly with juveniles. It is within peer groups that opportunities for drugs, drinking, and delinquency are first made available, most often occur, and are most likely to be socially reinforced. The process is one of peer influence, however, and is not a matter of severe and irresistible peer pressure.

There is some chance that juveniles will get into drugs and delinquency through the peer group and there is little that parents, schools, or the juvenile justice system can do about it. However, peer influence works both ways, indeed it is more likely to be in a pro-social than in an anti-social direction. Therefore, there is a good chance that the juvenile can be moved toward peers who take a negative view of drugs, alcohol, or other deviance, and will reinforce abstinence or at least limited involvement. This means that while it makes little sense for parents, let alone secondary authority figures, to monitor every waking moment, parents are well advised to exercise control over their youngster's friends, even though it may generate some conflict with the youngster. If the juvenile has come under formal and strict control of court or family services, even more stringent steps can be taken to oversee the peer relationships. But whether in the family or in a more controlled program, adolescents can be taught to make wise choices of friends. Drug education and prevention programs do not have a sterling record of success, but the implication

of the research literature is that the more they include education for positive peer influence the better chance they have.

Through a combination of demographic changes, improvement in family and divorce statistics, changes in attitudes, and impact of control and prevention programs, some positive behavioral changes have occurred in recent years in delinquency and drug use. I believe we can anticipate a period when adolescent deviance will be less of a problem than it has been throughout the 1960's and 1970's. Unfortunately, I do not expect this period to last.

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A Brief Commentary on Akers'

"Delinquent Behavior, Drugs, and Alcohol: What is the Relationship?"*

Travis Hirschi

Theories of Delinquency and Their Implication for the Drug/Delinquency Relation

To answer the questions "Does drug use cause delinquency?; Does delinquency cause drug use?; or Do they have some cause in common?", Akers goes directly to the research literature. This literature uses the traditional method of answering the question of causation. That is, it seeks to answer three questions. One, are the two variables correlated? Two, does one precede the other in time? Three, do they have a common cause? If the answers to these questions are: yes, they are associated; yes, one does precede the other in time; and no, they don't have a common cause—social science assumes that causation has been established.

The drug/delinquency connection clearly passes the first test. The two variables are associated; in fact, they are strongly associated. As Akers suggests, it is difficult to find social variables that are as strongly correlated as are drugs and delinquency.

**Highlights of a presentation at the Pennsylvania Juvenile Court Judges Research Seminar, June 1, 1984, Harrisburg, PA.*

Editor's Note: Professors Hirschi and Akers are colleagues and friends of long standing. Their general theories of delinquency causation, however, differ significantly. Akers is a proponent of social learning theory which suggests that we are born social and have to be trained to be criminal. In his view, delinquent behavior must be learned and supported by others, especially peer groups, if it is to persist. Hirschi adopts the social control theory which hypothesizes that we are born asocial and must be trained to be social. Consequently, the amount of learning required to become delinquent is trivial. Perhaps the major distinction between the two is the importance attached to peer groups. Hirschi believes that "birds of a feather flock together," and that individuals have the propensity for drugs or delinquency before joining a group and seek friends with similar propensities. Akers views peer influence as both a source and reinforcer of delinquent behavior. The differences between the two theorists are fundamental and lead to different conclusions about the connection between drugs and delinquency.

The second question, whether one variable precedes the other in time, however, proves ambiguous. Research has a hard time determining whether delinquency comes before drug use or drug use comes before delinquency. One reason research has such a difficult time with this question, is that neither "drug use" nor "delinquency" are adequately conceptualized. An individual apparently becomes a delinquent when he commits his first delinquent act, say shoplifting. And he becomes a drug user when he first consumes some drug, say has a bottle of beer. In effect we are asking: "Does shoplifting come before drinking beer?" This question does not make a lot of sense. It is obviously a matter of chance which of these acts the person will engage in first. The research literature agrees. Akers reports that current delinquency predicts subsequent drug use about as well as current drug use predicts subsequent delinquency. There is then, no reason to treat one variable as the cause and the other as the effect. This combination of results to our causal questions—yes, they are associated; no, there is no clear temporal ordering—strongly suggests that delinquency and drug use have common causes since they are associated without causing each other.

Professor Akers has prepared a list of the social correlates common to drug use and delinquent behavior. This list includes: gender, age, race, religion, family, and peer groups. I believe that most of these variables are important causes, or at least important correlates of crime. I would also agree that these variables are correlates of drug use. But what would happen to the relation between drug use and delinquency if we were to control all of these variables, which is what we would have to do if we wanted to test the idea that they account for the relation between drug use and delinquency.

We could artificially control them by finding a group homogeneous on sex, age, class, race, and the other variables, which is not hard to do. Let's look at boys aged 16, white, middle class, from a Northern city, with good families and with active peer groups. If these variables explain the relation between drugs and delinquency, there should be no relation between drugs and

delinquency in groups homogeneous on these variables.

I strongly believe (let me not be so cautious, I am morally certain) that drugs and delinquency will be correlated with each other within groups homogeneous on all these variables. The reason they will be correlated with each other, I would argue, is that **they are manifestations of the same thing.** This "thing" is not totally captured by the social correlates of delinquency and drug use. **This "thing" is the tendency to pursue short-term, immediate pleasure with minimum regard for the long range consequences of such pursuit.**

The Distinction Between Crime and Criminality and It's Implication for the Drug/Delinquency Relation

We need a word to distinguish short-term pleasure from its consequences. My colleague Mike Gottfredson and I have recently proposed resurrecting the old word "criminality" for this purpose. Criminality refers to the tendency or propensity of the individual to seek short-term, immediate pleasure. Such pleasure may be provided by ingesting psycho-active chemicals. It may also be provided by force or fraud. The mystery of the positive correlations between types of crime, between the use of one drug and another, and between crime and drugs is thus solved since these are all manifestations of the pursuit of short-term pleasure. The social correlations are so firmly established, that I have come to use them as a primary test of theories. If a theory cannot account for them, if especially it denies their existence, then the theory should be immediately abandoned.

To take an extreme example, **recall the theory that guided the Great Society programs of the '60s: the theory of Richard Cloward and Lloyd Ohlin.** According to this theory, people turn to crime when their legitimate aspirations are frustrated. According to this same theory, people turn to drug use when their legitimate AND their illegitimate

aspirations are frustrated. When you can't make it in legitimate society, you try to turn to crime; when you can't make it in crime, you turn to drug use. The theory is explicit on this point. So the idea, common in the crime and delinquency literature, is that drug users retreat from legal careers and they also retreat from illegal careers. They are, in short, retreatists.

This is all fine and good except for one thing. This theory says that the relation between drug use and crime is negative. That the more the person does one of these things the less he will do the other. But we know that the opposite is true; that the more you do one, the more you do the other. Therefore, **the theory is inconsistent with this basic fact and we should consequently avoid basing social policy on it.**

Positive learning theories also have a hard time explaining why drugs and crime should be positively associated. Such theories, **peer group theories, have no way of seeing and describing the common elements in crime and drug use.** On the contrary, what "goes together" seems to be at the whim of the peer group. The peer group could emphasize crime, or drugs, or crime and drugs. We have no way within the context of the theory to predict that these two phenomenon will be associated. Yet they clearly are associated in all the research available today.

Better to have a theory that predicts facts. **The fact is that the child must be trained, mainly by his family, to forego pursuit of immediate pleasure. The child must also have a stake in conformity; that is, he or she must have something to lose if he or she engages in delinquent acts. When training is provided by the family, when the child has a stake in conformity, he or she will think of the long range costs and benefits of his or her activity. He or she will therefore be less likely to use drugs and less likely to commit criminal acts.**

Witches and Wizards:

The Treatment of Adolescent Drug Abuse

Thomas Sumansky

In the field of adolescent drug abuse and chemical dependency, few findings and assertions are based on "hard" research data. So too for this article. The ensuing comments are "reflections" on the treatment experience at St. Francis General Hospital's Adolescent Chemical Dependency Unit in Pittsburgh, Pennsylvania. The wisdom and experience of Abraham Twerski, M.D., a stalwart patriarch of alcoholism rehabilitation and Dan Taylor, the founder of the unit, form the background for this article.

The purpose in writing this article is to document what we do, how we do it and why. We do not cure nor do we work miracles. Rather we do know how to treat the illness of the adolescent drug abuser, and I will attempt to acquaint the reader with our philosophy and methodology of treatment when a young person goes to a hospital.

There are no wizards—nor is there magic in what we do in treatment. Our basic belief is that chemical dependency is a fatal disease. It is a myth that dependent youth have some sudden insight and then seek treatment. They come to treatment only through a build-up of crises that, for a large portion of our admissions (40%), bring them before the juvenile justice system. When they are forced to seek help, many do well. The reality of that help is the focus of this paper. It is neither witch nor wizard, but it does offer hope, not of cure, but of remission and recovery.

What Are We Dealing With?

What is the extent of the problem? Depending upon what you read and how you interpret it, the data can be confusing. In a University of Pittsburgh study of the high school graduating class of 1982 in Allegheny County, about one-half of the class was drunk within a week of graduation. One in 16 seniors smoked marijuana daily (Stein, 1982).

Complimenting this study are statistics from the research conducted annually by the University of Michigan's Institute for Social Research, funded by the National Institute of Drug Abuse (NIDA). In a survey of seniors, more than 9 out of 10 had tried alcohol at some time; 7 out of 10 had used it in the previous month. Almost 6 out of 10 youths reported some use of marijuana. About 3 out of 10 had used it in the past month; more than 4 out of 10 had used marijuana in the past year. In general, more males were involved in illicit drug use than females. There was little or no difference between white and black students in the extent of drug misuse, but black students drank less alcohol than white students.

Regionally, the Northeast showed the highest rate of illicit drug use—in particular, marijuana, inhalants, hallucinogens, and alcohol. Chemical abuse was highest in large metropolitan areas: one in 16 smoked marijuana daily and one in 16 drank alcohol daily.

One notable finding is the early introduction to drugs. **Today, drugs more clearly demarcate the transition from childhood to adolescence than from adolescence to adulthood.** *The Weekly Reader* reported that one-quarter of all fourth graders felt pressured by their friends to try drugs and alcohol. By the time youngsters reached the seventh grade, two-thirds felt pressure to try liquor and one-half to try marijuana. Fifty-eight percent believed that some, most, or all of their classmates had tried marijuana (Borton, 1983). These are at best, conservative estimates.

For a significant number of youth, drugs have become

a regular part of their daily lives. Drugs are used to relieve boredom, alleviate pain, and negotiate normal pre-adolescent and adolescent behavior and development. Just the term "adolescence," as a particular developmental phase stretching from "latency" into young adulthood, is the most misleading and dangerous abbreviation. Differences between the young adolescent in puberty and the late adolescent considering his vocation in life are vast. The tasks are enormously different as are the behaviors. Behaviors that appear sick and frightening may be perfectly normal in pre- and early adolescence, while at other stages they may be the result of retarded development or pathology. What parents and the rest of us are faced with is differentiating what is "adolescence" and what is disease. Just where adolescence ends and sickness begins is a marginally explored area. It becomes even more complicated with the introduction of mood and mind altering chemicals at this enigmatic developmental stage.

Children have begun to view usage as a normal aspect of life. Misuse is too easily dismissed as normal adolescent experimentation with adult behavior—part of the process in the achievement of identity.

The questions raised are: Is it normal to routinely drink to get drunk, or to use drugs to get stoned? Does the troubled adolescent become the troubled adult?

Thus far, drinking has been too easily dismissed as normal for the teen. This appears to be changing as we have more evidence of its destructive impact on the lives of our children. Drug usage has always been viewed as problematic, though marijuana is viewed as less so.

Where is the line between use and misuse—recreational use and harmful involvement? All adolescent use is misuse.

There is no such thing as social or recreational usage among adolescents, if for no other reason that usage violates the law of our state, as well as every other state in the nation.

Young people do develop serious problems that demand

our concern. **Children who use chemicals have problems and children with problems use chemicals.** An astonishingly large portion are

harmfully involved. We can cite the one million teens who run away from home every year, the one and one-quarter million babies conceived by teenage mothers, the 80,000 youths in institutions, the one-half million children living away from home, the 30,000 adolescent suicides and 8,000 highway related deaths. How many of them are drug related? I do not know, but I do wonder.

In the Youth Alcohol Abuse Report, Michele R. Magri states:

"Generally, juveniles who drink are also involved in more delinquent activities, such as trouble in/with school, with police, shoplifting, and fighting. Several studies have demonstrated a relationship between adolescent alcohol (and drug) use and juvenile delinquency ranging from 84-90%. In one study, 43% of the delinquents studied had committed crimes while using. In another sample of older male adolescents convicted of various crimes, alcohol was the preferred drug. Further 47% of the assaults committed occurred while the assailant was under the influence of a drug" (Magri, 1983).

Some facts that we do know about usage are:

1. Peak use of drugs occurs when youths are completing adolescence and entering young adulthood. Initiation into drugs occurs at the pre-adolescent level.
2. The use of various drugs is interrelated—users of one type of drug are much more likely to be users of others.
3. There are developmental, not causal, sequences in usage patterns: that is, a progression in the use of drugs from alcohol to marijuana to pills, etc., rather than the use of one drug causing the use of the next type of drug.
4. Increased prevalence of usage is accompanied by a decrease in age of onset as well as more extensive and persistent involvement.
5. There are four broad classes of predictors of drug abuse:

- a. Parental use of alcohol and their attitudes towards drugs.
- b. Drug use by an adolescent's peers.
- c. Little or no involvement in activities.
- d. Children with weak personal, family and religious beliefs and value systems.

Most findings support the conclusion that earlier initiation into drugs is associated with subsequent misuse of that drug, lower performance in social roles, and greater involvement in deviant activities such as selling drugs and criminality (Kandel, 1982; Nusco, 1979).

Characteristics of the Chemically Dependent Adolescent

Much of the terminology in our field means different things to different people. Use, misuse, abuse, and dependency all vary in definition according to a particular school of thought. Abuse, as a category in the addiction and alcoholism field, is slowly disappearing from the literature. The trend is to utilize the term "misuse" instead of "abuse" in referring to alcohol and other drug problems. Misuse more accurately reflects how children affected by drug problems misuse their drug of choice. Abuse frequently carries moral connotations that can be distracting in discussing the problem (The Observer, 1983).

The language I use is that of chemical dependency—the compulsive urge to use in the face of significant personal or social consequences. The chemically dependent adolescent is one whose life centers around the use of mood altering chemicals, whether it be alcohol, drugs, pot, cocaine, etc. The chemically dependent person is a misuser who's usage has gone out of control. The misuser is the one who has problems or harmful involvement as a result of his usage.

The stages of chemical dependency are that the youth first experiences a rapid and pleasurable effect from his usage of chemicals—he has learned the "high" and how

to control the degree of the mood swing by regulating the quantity of chemical intake. Once learned, the recurrent state of mind persists. It is incurable.

Intoxication remains the most intensely personal experience the youngster can undergo (Berstein, 1973).

Secondly, he uses compulsively. He plans his usage and goes in search of the mood swing. Thirdly, he develops a powerful relationship to the drug. The drug provides a power and caring he has been unable to find in others or in himself. As he has learned to trust the chemical and its effects, he experiences periodic loss of control, growing preoccupation, and tolerance.*

Finally, these usages result in anti-social and self-defeating behavior. The loss of insight becomes a delusional system, self-imposed rules are broken, and the victim's life deteriorates. What he does under the influence violates his own morals and values as well as those of his family. He uses to feel normal. In the final stages of dependency, he uses to survive rather than to feel euphoric. Physical addiction follows.

Chemicals have replaced ego structure. A huge gap is left in the ability to integrate and synthesize experience. Uppers have left flailing, aggressive, destructive youngsters; downers create dull, depressed individuals; while acid effects passive personalities who are angry and bitter with their parents and their own inadequacy.

Dependent children are frightened of their own and others' anger and intensity, ever fearful of losing control. This they mask in passivity or aggressiveness in an emotional ping-pong game. With little inner resources or ego strength, they have a history of failure and a lack of motivation characterized by passive

*Loss of control is a condition where "normal" willpower is inadequate to control the use of the chemical, and is usually indicated by "black-outs" and memory distortion, larger and more frequent dosages, and harmful consequences. Preoccupation is a condition where the user anticipates and plans drug usage and develops a growing need to use during times of stress or to prevent stress. Tolerance is the point in the illness where it takes more of the drug to get the same desired effect.

hostility, and internal conflict evidenced by impulsivity, dependency, and diffusion.

Drug abusers are shielded or protected from the consequences and pain of their usage in almost every social system. For every dependent child, there is a corresponding co-dependent or "enabler" who shelters the child from his hurt and pain.

Enabling describes any action taken by a concerned person that removes or softens the effect of a harmful consequence of chemical use upon the user. Enabling prolongs the illness by hiding the symptoms from the afflicted person. Enabling seems like it should help, but it only makes things worse.

At school, the enablers are those who fail to expect responsible behavior and tolerate excuses for non-learning. In the community, irresponsible behavior is excused by churches, the law, and peers until it becomes so blatant that there is no one left to say "enough already" except the juvenile or criminal justice systems.

At home, this co-dependent, or primary enabler, is usually the parent of the opposite sex who centers his life around the child and his problems. Thus, we find the typical family constellation of one parent more intensely involved with the misuser and the other parent more punitive, distant, or absent.

Families feel they have no alternative but to hide the problem. They maintain the child as a misuser so as not to upset the family pattern. As they protect the child from natural and logical consequences,* they perpetuate the illness and consequent irresponsible behavior. Family members intertwine to create a balance designed to relieve stress. Soon the family is dysfunctional in relation

*Natural and logical consequences are an alternative to reward and punishment. By holding children responsible for their behavior, it allows them to make their own decisions about what is appropriate behavior. Hunger is the natural consequence of not eating; body odor of a lack of hygiene. Where natural consequences might prove dangerous, logical consequences permit a child to learn from the social order of mutual rights and mutual respect. They are impersonal, permit choice, relate to behavior, and are concerned with the present or future. Examples of logical consequences are to clean up a mess or lose a privilege, use an alarm clock or go to school late, do one's homework or get a failing grade.

to the dependency. Inadequacy, hurt, guilt, loneliness, and fear spell out the feelings of the siblings. Denial, rationalization, and projection characterize the dependent and his family (Wegsheider, 1981).

The presence of another dependent in the family is a major reliable indicator of dependency in an adolescent. The most frequent source of first drug use remains the home.

Frequently, adolescent drug misusers are the culmination of a multi-generational pattern of misuse. The child has grown ill from a disease that has engulfed the family for years. The vicious spiral of misuse and dependency escalates in the child.

The cause-effect relationship between drugs and the problems associated with usage is a continuously haunting question. At the present time there is no data proving that more extensive drug misuse leads to more problems or vice versa. We cannot even validate the reciprocal relation between the two factors. Yet experience tells us that the relationship is there.

A further consideration in the cause-effect spectrum is the similarity between dependency and various forms of adolescent psychopathology or mental disorder. In reviewing traits which characterize the drug user or the disturbed child, we note few differences. Lack of interest in school work and poor academic performance, for example, have been found to predict susceptibility to mental disturbances as well as anti-social behavior and drug initiation. Poor relationships with parents and lack of parental discipline are common precursors of character disorders, delinquency, and the use of illicit drugs (Kandel, 1982).

Future drug users, however, appear to differ from adolescents who will exhibit various forms of pathology in two important aspects: drug users are of average, even superior intelligence and they are peer-oriented rather than isolated. Both of these indicators are borne out in our evaluation of adolescent misusers. Using drugs by oneself and alienation from the peer system are fairly consistent indicators of pathology.

One description of the chemically dependent child states that prior to treatment, the child feels good and has no problem while everyone around him is in pain. The sad and lonely child is much less receptive to drug treatment and usually has exhibited less oppositional behavior harmful to others.

Treatment Services: An Historical Perspective

Early efforts to serve the young were generated by the mental health system, which focused on intervention and treatment of behavioral and emotional problems. Alcohol and drug usage were considered symptomatic of a personality or behavior disorder. In the early 1970's, there was little effort to develop approaches to the special needs of adolescents. Treatment utilization by the teen was low and this tendency continues to the present.

By the mid-seventies, programs aimed at the special needs of youthful drug abusers began to emerge. The earliest programs concentrated on heroin addiction. From these emerged separate youth programs in the drug field. Actually, three models evolved. One sprang from the mental health approach that adolescent drug abuse is a symptom of other emotional and developmental problems. The second based its methodology on the disease model of alcoholism and followed the principles of Alcoholics Anonymous (A.A.) and the Twelve Steps of Recovery in a highly structured milieu. The third was the religious model as exemplified in the work of Herb Wilkerson in the streets of New York City and led to programs similar to Teen Challenge. The basic message states that only in the acceptance of Jesus Christ as a personal Savior will one find freedom from the slavery of drugs (Nusco, 1979).

Prevention services stressing alternate highs, healthful use of leisure time, and drug and alcohol education sprang up everywhere. Soon however, the funding dried and programs concentrated on intervention and treatment, rather than prevention. Outpatient services offered storefront, agency, and drop-in centers. Rap groups turned into therapy groups.

Within the past three to five years, we have seen the growing acknowledgement of the impact of the family system upon effective treatment. **Programs of all kinds—outpatient, outreach, residential—are making great strides in engaging families in the treatment process. This involvement is the most significant and important development in the treatment field in the past twenty-five years.**

What is the approach of choice? No definitive information is available. A wide variety of programs exist. Approaches range from strongly supportive peer environments to highly confrontive and intensely personal involvement in a therapeutic community, or some combination thereof. Many treatment modalities have earned the respect and admiration of both public and private sources. Again, most noteworthy among these varied programs are the many commonalities. These include: 1) a recognition of drug and alcohol concerns; 2) the provision of intensive treatment focused on the adolescent, his peers, and family; and 3) reliance, to some degree, on the tenets of Alcoholics Anonymous and the support this group offers.

One important variable remains, the length of stay and follow-up. The adult-oriented 28-day model seems too short for the complexity of adolescent issues. Yet the removal of the child from family and community for longer periods of time appears much too restrictive.

The primary exception to short-term treatment, however, is the delinquent situation. Once a child does become involved with the legal system, there is a much greater likelihood that he will be remanded to long-term (9 to 18 months) treatment as an alternative to institutional commitment. The juvenile justice system appears to be adopting a more therapeutic, rather than punitive approach to the problem. **Although commitment is initially viewed by the child as punishment, there is usually great relief in the knowledge that the drug issue will be addressed. Unfortunately, the length of**

stay depends more on the extent of legal involvement than any valid diagnostic or evaluation criteria.

The Therapeutic Community: Aspects of The St. Francis Program

In our opinion, the therapeutic community provides the best results in the treatment of adolescent chemical dependency. The imposition of external controls allows the flailing youngster time to acquire an internal locus of control.

Working from the assumption that the chemically dependent adolescent lacks ego development and ego boundaries, the therapeutic community provides the opportunity to learn to establish boundaries. Elements of this treatment approach include patient responsibility, an open door communication system, and family and patient involvement in decision-making. A further critical perspective to treatment is the awareness that the adolescent is a special type of patient. The fundamental developmental issues of emancipation, sexuality, socialization, vocation, and the formation of ego identity are explored. Feelings aroused by interpersonal and intrapersonal conflict can surface to find expression and completion in a safe and healthy environment.

The clear and definite patterns of program organization and structure use self instead of ego. Clear roles, predictable routines, and defined lines of authority are organized to provide treatment for the adolescent. In this setting, the adolescent can practice functional, social, and productive behavior within a safe and rational environment with immediate feedback.

The St. Francis program utilizes a quasi-therapeutic community approach with families. To avoid cutting the child off from the family or deflating the status of parents, the program must provide constant support to the family. This entails considerable vigilance and advocacy on the part of the program. A goal of treatment is the reintegration of the adolescent into the

family. This includes family restructuring and resolution of conflicts and relationships, whether the child continues to live with the parents or in other settings. Multiple family support and therapy groups meet several times a week.

A further enhancement of the program is the utilization of recovered patients. Contact with recovered persons provides the adolescent with a sense of the reality of the illness as well as the outside world. These recovering people embody within themselves the belief in the patient's ability to help himself. In this way, the treatment environment communicates warmth and understanding.

The program has a here-and-now orientation. The present focus is employed to explore harmful involvement with drugs and its relation to present behavior, in the hope that the patient will reject maladaptive behavior to learn new drug-free ways to live. Patients learn to evaluate their behavior in terms of whether it helps or hurts themselves or others. **Destructive behavior needs to be changed. For a chemically dependent adolescent, there is no excuse for irresponsible behavior—period.** Patients have developed habits of excusing their behavior and blaming its consequences on the failures of others; hence, the importance of learning a sense of personal responsibility for one's own behavior.

Commitment, that "bugaboo of treatment," is first obtained in compliance to the program. Usually the youngster experiences this as a "con" game that may return to haunt him in recovery. However, the compliance or "con" is essential and healthy in gaining commitment to staff and peers as a transition. Ultimately the patient makes a commitment to self.

Contracts initiate the journey to recovery and mark each significant step along the way. There are written and signed contracts. Failures do occur. These are opportunities to re-negotiate and re-contract for desirable behavior. Here the staff needs the self-discipline to ask when and how the patient is going to do "what you

want to do" rather than to understand why the patient will not. **Patients respect the belief we have in them, that they will act in a responsible, caring way when we recognize and refuse to accept their excuses. In this way, we break the repetitive cycle of enabling.**

This respect, in turn, leads to trust and love for us and eventually of themselves for themselves. A sense of self-worth and maturity develops with the achievement of small reachable goals.

Treatment begins with a clear, factual, and precise look at irresponsible behavior. The next step is to identify those behaviors judged by the patient as hurtful—primarily misuse of drugs. Once these are identified, specific plans are made to change. Most adolescents fear change—that it will somehow diminish an already deflated self. Change slowly begins to feel good. In the therapeutic community the patient experiences the natural and logical consequences of his behavior as well as the success of change. His peers provide information on how this behavior impacts upon them. This is frequently in marked contrast to what the patient thinks or believes. **The ability to achieve congruence between one's thoughts or beliefs and the reality of the impact of one's behavior is the hallmark of health.** The chemically dependent youngster absolutely believes that if he thinks something is right or good, then it has to be that way. As he develops his ability to reality test, he slowly breaks through the chemically induced delusional system to utilize cognitive and relational skills not previously learned.

The Adolescent Chemical Dependency Program

Those are the tenets of treatment; now let us examine their practical application by our unit. Referrals to our program come principally from parents, courts, and schools—the three systems that have developed the sophistication to identify and refer misusing teenagers. Churches and social agencies appear far behind in the area of identification and referral.

All treatment must begin with a "no use" contract. It is impossible to reach the adolescent who is using drugs. Chemicals do two things: 1) they alter reality—they change the way we think; and 2) they alter mood—they change the way we feel. We cannot compete with the chemical and its effects. It is fanciful to believe that drugs do not work or that we can make a youngster aware of harmful consequences as long as they are high.

Evaluation

Upon admission, we go about the work of evaluating and diagnosing. We firmly believe these should be kept separate from treatment in order for us to know what to treat. The evaluation process is a seven to ten day ascertainment of the extent and consequences of drug misuse. The patient remains in a closed unit on a voluntary commitment. Each child prepares graphs outlining the history, amount, and frequency of usage. These are tied into significant events in the patient's development and life history. Past usage is explored in relation to current functioning, to evaluate its consequences, and to make personal value judgements. Secondly, the child prepares a series of "Ten Harmfuls"—an in-depth look at the consequences of drug usage. Educational and theme-centered groups reinforce the evaluation.

Most adolescents continue to progress in their misuse or illness until others recognize the problem and intervene. Even at quite early stages of misuse, the denial of harmful involvement is firm and progressive. In fact, the "euphoric recall" and the "delusional system"* are so well entrenched that the dependent adolescent genuinely believes the falsehoods. Thus, it is critical to develop a documented history of facts and observations regarding the pattern of behavior and attitudes. Attempts

*Euphoric recall is the perceptual distortion caused by the pharmacological properties of the chemical which results in the user remembering only the feeling response during intoxication, not the behavioral response. Delusional system is the result of the defense mechanism. Rationalization, projection, and denial characterize a way of life which puts the dependent person out of touch with reality. It is the impaired judgement that keeps the youth locked in a self-destructive pattern.

at insight are practically useless at this point in the program. Only the power of reality is capable of breaking through the deeply ingrained defense mechanisms that prevent adolescents from recognizing and accepting painful truths. Breaking through the delusional system permits treatment to center on behavior changes, values, contracting, and commitment.

As nearly 20% of all our admissions are referred elsewhere for psychiatric care, the recognition of emotional disorders and pathology is important at this point. Differential diagnosis clearly delineates what the problem is and what needs to be treated. Evaluation also differentiates misuse from dependency. To proceed into the treatment phase of the program, the child must meet the criteria of progression, tolerance, preoccupation, and disruptions in at least two significant life systems such as family, school, peers, and the legal system. Children who do not meet these criteria are referred to outpatient drug treatment which focuses on behavior change and family therapy. Intervention and outpatient services work well with the drug misuser who can look at consequences and determine that these hurt. However, the usage and social context for many adolescents demands removal for a period of time from the using environment to a safe and drug-free environment. At its best, this involves medical evaluation, a therapeutic community, and family restructuring.

Finally, exploration and confrontation of parental chemical misuse are necessary. Yet, these must be gentle and understanding rather than blaming and judgmental. Anger, competitiveness, and disrespect toward parents have no place in family treatment.

Transition

Upon completion of the evaluation process, an interdisciplinary team reviews the data and formulates its diagnosis and recommendation. The critical transition from evaluation to treatment now occurs. Every patient meets first with his parents to present his drug history

and consequences of abuse. The parents' abilities to convey specific, concrete data and give a clear, open message to the child come to the fore at this point.

For the child entering treatment, we begin the exploration of the relationship between the child and parent. We also encourage some tangible recognition of the relationship. Our experience has been that **parents:**

- 1. are astounded at the extent and prevalence of drug usage,**
- 2. have strong feelings of shame, guilt and personal failure,**
- 3. begin reconstruction as they state that this is usually the first meaningful communication they have had with their child in many years.**

The second element of transition is the presentation to the peer treatment group. To enter treatment, the patient must present a review of usage and harmful consequences, explore the purpose and goals of treatment, and request acceptance from his peers. This presentation serves the function of introducing the patient into the therapeutic community and obtaining an initial tenuous commitment. Children unable to navigate this process generally are not ready for treatment or need referral to a more appropriate, longer-term program.

Treatment

Treatment shifts the focus to the present and to involvement in the therapeutic community. Ego restructuring and behavioral change are stressed. These are accomplished through: 1) a clear and rigorous structure of environment; 2) individual, group, and family psychotherapy; and 3) educational, occupational, and recreational therapy. Alcoholics and Narcotics Anonymous meetings are held 3 times a week on the unit. A pool, gym, and outdoor and indoor recreational resources, and field trips are utilized. However, there are no radios or televisions.

Treatment is intense and focused and centers on the philosophy of the first five steps of A.A., beginning with the exploration of control and personal responsibility.

Patients explore their fears, anger, and sense of loss or pain in the first step of primary treatment. Perceptions of self at this time tend to be feelings of inadequacy, loss of control, and anger. Children come to learn that their anger will not destroy them or someone else when they express it. Working through anger marks a critical point as to whether patients choose to leave treatment or continue on.

The second step of therapy moves the patient on to explore the lack of significant relationships in his life. Patients begin to thrive as they identify specific adult and peer relations—investing time and effort in their cultivation. Development of trust and risk-taking provides for more active involvement in the peer system and community. It also develops a skill that hopefully will be transferred to other recovering peers and a sponsor in the A.A. program.

The third step explores the patient's relation to and involvement in the group and program. The higher power concept frees the adolescent to trust and relate to others as well as to take responsibility for himself and others.

At about this time, the patients are involved in Family Week. This involves the parents—including single parents, step-parents, separated and blended families—along with siblings and often grandparents. Here the family structure and system is explored in depth. Education in the family nature of the illness is presented, and each family defines goals for the week. It is a five-day, 40-hour, intense multi-family, therapeutic experience. In a sense, the families develop a mini-therapeutic community of their own that often lasts well after the treatment experience. **The purpose of Family Week is to begin family restructuring, since the family cannot return to its old style of relating and behaving.**

The Twelve Steps of A.A.

- 1 We admitted we were powerless over alcohol— that our lives had become unmanageable.
- 2 Came to believe that a Power greater than ourselves could restore us to sanity.
- 3 Made a decision to turn our will and our lives over to the care of God *as we understood Him*.
- 4 Made a searching and fearless moral inventory of ourselves.
- 5 Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
- 6 Were entirely ready to have God remove all these defects of character.
- 7 Humbly asked Him to remove our shortcomings.
- 8 Made a list of all persons we had harmed and became willing to make amends to them all.
- 9 Made direct amends to such people wherever possible, except when to do so would injure them or others.
- 10 Continued to take personal inventory and when we were wrong promptly admitted it.
- 11 Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
- 12 Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Because the whole family is ill, any modality of treatment for young people on drugs must involve the entire family. The child requires a caring and feeling environment—one that responds to his need to give pleasure and bring joy to the parents. This response confirms the child's existence and is the beginning of self-worth. Secondly, the child begins to merge into the strength of the powerful adult and to acquire a firm and resilient self. This exploration and clarification of the relationship with one's parents and family frees the child to socialize—to become part of the therapeutic community—to trust and risk.

As the child senses a freedom from the ancient dragons of non-self and helplessness, as the child differentiates a self distinct from the parent, he progresses to the fourth step of a searching moral inventory. Here the patients explore their successes as well as their failures. They compose a startling inventory of their assets and deficits. For issues seeking acceptance and forgiveness, the fifth step is taken with the Pastoral Care Counselor. The fifth step is a review of one's life as written in the course of treatment and all the hurt and pain that accompanies it. The experience is one of sharing, acceptance, and forgiveness.

Each patient is assigned a Primary Nurse and a Primary Therapist with whom to work actively to form and resolve a relationship. Other essential elements of the program include a Daily Journal—reviewing the events, feelings, and achievements of the day. Another is the Life History or Autobiography that is part of step two and three. The considerable amount of written work based on the principles of A.A. is reviewed by staff and presented to peers for acceptance.

Significant Highlights of the Treatment Phase

One of the most notable characteristics of the adolescent in treatment is his spirituality. Adolescents are not very religious, but they are highly spiritual.

This natural sense of reflecting inward upon oneself and discovering inner life and values intrigues the

adolescent. It is the outgrowth of abstract thought and formal process that forms the "ultimate high" of adolescence. Sharing this experience involves a warmth and intimacy in the peer system unrivaled by any intoxicant or altered mind state.

The Wizard of Oz, an allegory on the spirituality of recovery, inevitably fascinates our clients. They see themselves as Dorothy walking the Yellow Brick Road of A.A. searching for a heart, a brain, and the courage to put it all together. They encounter numerous obstacles—from poppy fields to wicked witches in search of the Magic Miracle the Wizard holds out to them. In the end, they discover there is no magic—no one program or treatment—that provides an easy or magic answer. The answer lies within themselves (in their spirit) that only in giving of themselves to reach out—to love and to care—can they find the good witch who guided them with spiritual shoes. In rejecting the narcissism of chemicals they find the power of their thoughts, the warmth of their hearts, and the strength to search within for their answers.

It is this spirituality of the adolescent that emerges in proper treatment. **The Program does not glorify nor credit itself for wizardry or magic but constantly strives to open the mind and heart to the wonder of contemplating one's own self as separate and unique. This allows for the courage to make a decision and commitment to sobriety and health which no human force can impose.**

Two other elements stand out in treatment for us. One is the ongoing interaction between parent and child throughout the program. Parents work their steps of recovery along with their children. Parents learn about the illness, recovery, and spirituality with their children. The work of separation/individuation in adolescence lies in direct conflict with the pervasive and powerful entanglement between child and parent found in illness. Roles need to be defined, responsibilities stated, commu-

nication established, and consequences experienced.

Parents need to be taught the language of feelings: that anger is really hurt or loss carried into the present; that anxiety is the expectation of hurt and loss in the future. So much of separation anxiety at the approach of program completion is the haunting sense and expectation that the pain and loss of the past will continue on into the future—at home, in school, or with one's peers.

Finally, the little tricks or aids that make therapy fun include the magic in a projective exercise; the thrill of the future in vocational exploration; the ease of relaxation in calming our body's responses; and the absolute ecstasy of guided imagery to view one's self as whole and competent, good and unique, loved and lovable. There are excursions into sexuality, the meaning of being a man or a woman.

All in all, a thirty-day program seems too short a time. Every patient enters the unit indifferent to the destruction of the disease while those around him experience the pain of his illness. Yet every graduate leaves with tears in his eyes while those around him congratulate the growth he has accomplished. The final circle or graduation ceremony joins the therapeutic community, staff, patient, and family to say Goodbye...To Reminisce...To Begin a New Life.

At this point, both patient and family begin the process of re-entry. The transition from treatment to the cold, harsh world reminds us of birthing. Will he make it? Can the growth experienced and skills practiced be integrated by the patient and his family? The first 6-9 months appear to be the most critical period.

Aftercare

After opening the program, we soon learned that our children had few resources or support systems beyond A.A. available to them upon returning to their homes. Their parents had the POTADA (Parents of Teenage Alcohol and Drug Abusers) or Al-Anon support system available to them. The children, however, returned to the

old social context. There was no support for sobriety in an alternate peer system available to them.

Most of our patients had utilized the peer network in an anti-social manner. **The need for community resources supportive of the patient's changed lifestyle was clear.** Such changes are maintained only with persistence, support, and great effort. The supportive activities of aftercare encourage social, responsible, and drug-free behavior.

Upon program completion, our patients were quickly and easily assimilated into A.A./N.A. self-help groups, working the traditional 90 meetings in 90 days. Each had been advised to begin working the first step of A.A. again as they had learned how to do it. Then they actually had to do it.

Soon, however, we found this to be insufficient. Even children in families utilizing therapy and self-help groups to restructure their relationships found difficulty in making the transition. Skills acquired and practiced in treatment appeared unreal at home, at school, and in the community. The experience in the therapeutic community conjured up feelings of conning and worthlessness as the recovering youngster struggled to grasp the reality of home and school. We quickly moved to provide a 6-week program of multiple family therapy and a 9-month, three level program of group therapy encouraging greater independence at each level.

Level One stressed the issues of sobriety, leisure time, and alternative highs. Level Two explored interpersonal and intrapersonal relations, in particular, human sexuality and life planning. Educational and vocational areas were addressed as well as personal and spiritual growth. Level Three involved the issues of guilt and forgiveness. Outreach to other teens completed level three work. Patients completing this vigorous course of aftercare, achieved phenomenal success and continue to do so today.

However, the area most neglected was the social and educational context. Our patients returned immediately to school with its concomitant dangers. As regressions

or slips occurred and were explored in group or individual therapy, they related frequently to the peer network at school or in extracurricular activities. Nothing here had changed. The recovering adolescent was perceived as somehow different or changed. However, the pressure to return to old alliances and images remained as strong as ever.

To provide adequate aftercare resources, we needed the schools as our allies. We began by training school counselors in the provision of aftercare services. School counselors spent a week on the unit moving through and experiencing the evaluation, treatment, and family components. Most had the training and skills, from their counseling backgrounds, to be effective. They needed the experience and permission to deal directly with the nemesis of drug misuse. They simply needed to learn to intervene effectively. As schools sent counselors for training, they gained the permission to address the drug issue head-on.

Aftercare support groups for recovering adolescents were developed to replace the old peer and using system. Such groups offered the aftercare clients a haven in the school setting when an urge recurred or feelings became shaky. As aftercare groups have functioned over longer periods of time, their worth and effectiveness have spawned questions of what more needs to be done to prevent, educate, and intervene. As a result, insight and intervention groups have been developed. Insight groups focus on education and prevention of drug problems with an emphasis on self-esteem and decision-making. Intervention groups focus directly on assessing the extent, implications, and consequences of drug misuse and contracting for appropriate learning behavior.

Some schools have appointed drug-alcohol counselors to full-time positions. Ultimately, a few school systems have developed full scale Student Assistance Programs, based upon the Employee Assistance Programs developed in business and industry. These have proven to be phenomenally successful in the areas of prevention, education, intervention, and aftercare through their

emphasis on behavior conducive to learning and a therapeutic, rather than punitive, approach to drug abuse. Community aftercare groups also developed to support sobriety and promote responsible use of leisure time. As more and more graduates utilized these support services, the chances of recovery and maintenance of sobriety increased.

The next step came as our patients found a home in one or the other of the aftercare school or community groups. Attendance at aftercare corresponded strongly to their continuing sobriety. At the same time, we found an ever increasing demand for family services. Families' needs were not met in 6 weeks. Parents wanted more individual and group time. Thus, we decided to encourage our patients to utilize the aftercare services at school or in the community as these had grown significantly. We increased our resources in Family Programming by scheduling multiple family groups weekly for at least 3 months and longer, if needed. More time was also allotted for individual family therapy. Those families needing marital therapy were referred to private or public sources.

Upon completion of the family segment, the patients are seen for individual work in the areas of life planning, interpersonal relations, sexuality, and guilt. The patients also begin to return to the in-patient unit once a week to work with new patients as part of their outreach. Our Saturday Morning Alumni Group, in which former patients direct the session under the supervision of one of the therapists, has become a highlight of the week.

The strong and effective involvement of the Allegheny County Juvenile Court and its probation officers has been an important element of successful aftercare. This care and interest are seen in their regular visits to the unit and help in monitoring the aftercare contract. They routinely check to insure participation in therapy and involvement in A.A./N.A. Many of the probation officers are highly skilled individual and group counselors themselves and have participated in numerous educational and training seminars at St. Francis or elsewhere.

As noted, aftercare and continuing care of the drug misuser involve a continuing and trusting consortium of the therapist, family, school, and the court. When one element is absent, the prognosis for success diminishes significantly. Therefore, the key factors in aftercare are the combining of viable peer support systems for both child and parents, and the ability of the various concerned systems to interface and interact for the welfare of the child and family.

In one year follow-ups of graduates from treatment, we continue to find a strong correlation between a child's recovery and the parents' participation and involvement in a strong parental support and self-help group.

These may be Parents Anonymous, Tough Love, POTADA or Al-Anon; the important element is the commitment of the parents to change.

Ultimately, the child returns to the "real objects" in his world—his parents, siblings, peers, teachers, and other adults. A child who is fortunate will come to love his parents again. Parents need not love their children passionately; children, however, do need to love their parents. No competent aftercare or treatment person will seek to undermine or replace that love.

The old maxim in child psychology that the child's treatability is a function of the parents' workability is no where more true than in drug abuse treatment. When parents fail to work along side the child in treatment, we have found that only about one in three do well. Where parents work with their children for at least 3 months, the rate about doubles. Finally, when the family and patient work together for a year after treatment, the chances of success are better still.

Conclusion

In conclusion, the best prevention lies in basic education, breaking the cycle of dependency and co-dependency in the system, and ensuring that individuals function at

their capacity in their roles. Intervention or the creation of a crisis by concerned persons is the key at the junior and senior high school level. Intervention permits the presentation of specific and firsthand information about the facts of a person's drug misuse by meaningful and significant people. The crisis is precipitated by this presentation of the reality of the illness and its symptoms. The crisis is a cry for help often unheard or misunderstood by involved persons who do not know how to listen for it. In looking at the lives of our patients, we have found a build-up of crises that has forced them to look at the reality of their condition. The adage of "I'm sick and tired of being sick and tired" holds true. The only way back to reality is through crisis.

Early intervention means significantly less destruction to the child and his family. Good treatment follows to accomplish individual and family restructuring. Finally, effective aftercare, the maintenance of gains made in treatment, assures ongoing sobriety and health.

The frustration of seeing children do relatively well in a treatment program and then return to usage after discharge is a dilemma to the professional and community alike. We are just beginning to gain some perspective on what direction to take. We need to find innovative ways of working with impacting systems, such as the courts, schools, and community.

Impacting such systems is critical. One basic rule of intervention is that alone, in a one-to-one confrontation with misuse, we are greatly undermanned. By including one other system on our side, we are basically even in the struggle with an adolescent and his peer system. As we join hands with other systems and work co-operatively, we significantly increase our chances for successful remediation of the problem.

A final consideration is that of evaluation and outcome studies. Despite all the literature available, there seem to be only a few pamphlets that actually tell us what works and what doesn't. Every program, including ours, claims high success rates. However, the basic criteria to measure success are still quite elusive: subjective-

objective, abstinence-responsible use, achievement-personal satisfaction. The maintenance of treatment results are also difficult to document as longitudinal studies are not available. Even the basic criterion of abstinence appears to be fading as more and more treatment centers view abstinence as unreal in the light of our social context and its promotion of social, recreational, and medical drug usage. Hopefully, this article will encourage interest to explore these areas further.

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